

**217Research Project**

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**Evidence-based practice: A trainee clinical psychologist  
perspective**

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## **Table of Contents**

Abstract	1
Statement of contribution	2
Acknowledgements	3
Journal Paper	
Abstract	4
Introduction	5
Method	20
Results of analysis	30
Discussion	43
References	58
Extended paper	
Extended background	71
Extended methodology	110
Extended analysis	136
Extended discussion	178
References	212
Appendices	
1. Journal submission guidelines	237
2. Ethical approval letter	243
3. Participant information sheet	244
4. Participant consent form	248

5. Participant demographic form	249
6. Transcriber confidentiality form	250
7. Focus group schedule	252
8. Participant Debrief	253

## **Abstract**

Evidence-based practice (EBP) is now the dominant model in health care; its aim is to increase the use of research evidence to inform clinical decision making. Clinical practice guidelines are the predominant method by which research is distilled into practice recommendations. Clinical psychology has its own model which promotes the integration of research evidence with clinical expertise, the scientist practitioner model (SPM). Recent developments within the United Kingdom health service, such as the Improving Access to Psychological Therapies programme have stimulated debate about the types of evidence that is often prioritised within the EBP model. This study aimed to explore these concepts with current third year clinical trainee psychologists, with a view to seeing how they construct these models. The findings suggest that the SPM may be more accurately termed the reflective-scientist-practitioner, or the critical-reflective-scientist-practitioner; in acknowledgment of the importance placed on these skills by participants who saw them as central to their role. The current study indicates participants were unaware of the APA (2006) definition of EBP; recommendations include that clinical training courses consider including teaching around both models, exploring the complexity of the underlying debates, in doing so trainees will be more informed about the models that shape their chosen profession.

## **Statement of contribution**

I, Lynn Chapman

Declare that the thesis entitled

Evidence-based practice: A trainee clinical psychologist perspective

and the work presented in the thesis are both my own, and have been generated by me as a result of my own original research. I confirm that:

- this work was done wholly in the candidature for a research degree at this University;
- where I have consulted the published work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
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## **Abstract**

Evidence-based practice is a dominant model in health care. The model has been actively endorsed by some, who perceive it as aiming to limit variability in practice; while it has been a cause for concern for others who perceive such a model as restricting their practice and undermining their clinical judgement and expertise. The consequence of such diverse views impacts on whether evidence based recommendations, such as those endorsed in clinical practice guidelines, are implemented. The scientist-practitioner model has been the guiding model for clinical psychology and aims to link research with practice. Exploring practitioner attitudes to such models has been identified as important in terms of exploring how these models are constructed, and to establish the types of evidence clinicians utilise within their practice. These models were explored within three focus groups conducted with trainee clinical psychologists from three doctoral courses in the UK; thematic analysis was used to analyse the transcripts. The main findings and implications are discussed and considered with reference to the existing literature.

**Key words:** Evidence-based practice, scientist-practitioner model, clinical psychology, NICE, IAPT.

## **Introduction** (see Extended Paper, Chapter 1)

### Evidence-based practice

Evidence based practice (EBP) has been defined as the: “integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences” (American Psychological Association (APA), Presidential Task Force, 2006, pp. 273). There has been an increasing emphasis within health care services to adopt EBP, in particular to follow recommendations outlined in clinical guidelines (Department of Health, 1996, 2001). It has been purported that adopting EBP will result in reducing the variability within practice, by moving decision making away from intuition and towards the use of research findings (Department of Health, 1997; Pilling, 2008). Trinder and Reynolds (2000) state that adopting an EBP model in health care will result in greater use of evidence, more effective treatments, more efficient use of resources, transparency and accountability in clinical decision making and will empower both practitioners and patients. However, there has been much debate within the psychological therapies profession, and the wider healthcare system, regarding the potential implications of such a move (Levant, 2004; Miles, Hampton and Hurwitz, 2000). Part of this concern relates to how ‘best evidence’ is conceptualised and whether particular types of evidence are promoted over others (Corrie and Callanan, 2000). Dallos and Vetere (2005, pp. 20) suggest the EBP model “privileges one kind of evidence, which is



predominantly randomised controlled trials (RCTs) and evaluations of clinical interventions. However, this may not be the kind of evidence that is of most value to clinicians". Grypdonck (2006) suggests there are many forms of 'evidence' that may be drawn upon to guide practice; including but not exclusively limited to research. A related fear is that EBP may represent a move towards more manualised and prescriptive forms of therapy (Azur, 1999; Parry, Cape and Pilling, 2003; Pilling, 2008). However, alternative perspectives view EBP as "an ideology that promotes lifelong learning and best prepares graduate students for ethical clinical practice throughout their careers as psychologists" (Babipne, 2010, pp. 443). While EBP is a model which has developed across health care; within the clinical psychology field historically the predominant model for integrating research and practice is that of the scientist-practitioner (Shapiro, 2002).

**Clinical Psychology: Evidence-based practice and the scientist-practitioner model** (see Extended Paper, Chapter 1.2 & 1.4)

The SPM arose from the 1949 Boulder conference in Colorado, USA; held in part to develop the core training needs of clinical psychologists (Baker and Benjamin, 2000). This framework emphasises the importance of psychologists being equally adept at research and practice (Barlow, Hayes, and Nelson, 1984). The implication or intention of this approach; is that psychologists, as well

as operating as therapists, are also actively contributing to scientific psychology through conducting research (Corrie and Callanan, 2000).

Luebbe, et al (2007, pp. 645) perceive the SPM as being consistent with EBP, as this too has "at its core the improvement of therapeutic outcomes through the integration of clinical practice and clinically relevant research". However, whether the model adequately captures the role of the clinical psychologist is a source of debate (Baxendale, 2006; Milne and Paxton, 1998; Warner, 2006). This is due in part to the findings that research output for qualified clinical psychologists is relatively low, which has been taken as evidence that the model is impractical, or unrepresentative of the actual work carried out by clinical psychologists (Head and Harmon, 1990). Although, it has been suggested that service constraints may prevent clinical psychologists from conducting research (Cooper and Turpin, 2007). One of the criticisms directed at the model is the assumption that being a scientist-practitioner means being a producer of research, rather than being a sophisticated, informed consumer of research; such a restricted conceptualisation has contributed to the call for a reformulation of the SPM, to incorporate more complex understandings of the practice of science (Corrie and Callanan, 2000).

## **Clinical Practice Guidelines** (see Extended Paper, Chapter 1.3)

One of the main methods by which research is disseminated in order to influence practice is via Clinical Practice Guidelines. These are defined as, systematically developed statements that aim to assist practitioners and patients in making decisions about the most appropriate health care (Field and Lohr, 1992; Parry, Cape and Pilling, 2003). The main producer of guidelines for mental health is the National Institute for Health and Clinical Excellence (NICE, 2007, 2009), alongside those produced by the Department of Health (DOH, 2001). Clinical practice guidelines aim to achieve several functions: to collate and summarise research, to make recommendations for practice based on these summaries, to actively influence clinicians' practice, improve patient care, inform patients, guide commissioners and direct resources towards the most effective treatments (Grimshaw et al, 2004; Grol and Jones, 2000; Pilling, 2008).

Guidelines can be based on the results of systematic reviews, which are amalgamations of the results of a large number of research studies. Systematic reviews are concerned with establishing the efficacy of an intervention primarily via the highest grade of evidence the randomised control trial (RCT) (Moher et al, 1995). RCTs are a method for conducting research which aims to determine whether a cause and effect relation exists between treatment and outcome. Participants are randomly allocated to either a treatment or control group (the control group is the treatment as usual or no treatment

arm of the trial, or another treatment programme), pre-treatment; both groups are compared on predetermined outcomes. The result is that any difference in scores or outcome between the groups is then attributable to the intervention or treatment (Sibbald and Roland, 1998). However, Kazdin (2008) questions the generalisability to 'real-world' contexts of the types of recommendations arising from efficacy research. He states there may be evidence for specific interventions in the highly controlled contexts in which they are studied, but translating them into clinical contexts which are arguably more complex, may be problematic (Long, 2008). Clarke and Barkham (2009, pp.10) suggest the question is whether "evidence-based practice is fulfilling a potential to enhance and support the art of better clinical decision making, or whether guidelines impose a straightjacket that makes 'integrating individual clinical expertise and the best external evidence' more difficult in practice, thus reducing quality of care?".

The philosophy of science and differing perspectives regarding ontology and epistemology underpin part of the debates around EBP and the SPM. Traditionally the physical sciences and medicine originate from a positivist perspective. Chwalisz (2003) describes how historically the desire of psychology to be established as a scientific discipline, illuminates its alignment with a logical positivist philosophy of science. It is research that emanates from this framework that is generally placed at the top of the evidence hierarchy. Consequently,

those whose epistemological position differs from this dominant paradigm, consider the current conceptualisation of 'evidence' to be limited, and suggest that in order to capture the complexity of psychological phenomena there needs to be a move away from positivist scientific methods (Harari, 2001).

In summary, evidence-based practice has become a dominant framework across many professional spheres; this has been met with a mixed response, from outright dismissal and outrage to welcoming acceptance. A central method for translating the evidence from research into recommendations for clinical practice is via the development of guidelines. These too have their share of proponents and opposers based on a multitude of considerations. Research in this area has attempted to delineate and illuminate these various positions through exploring clinicians' attitudes towards EBP in the context of their everyday practice.

**Practitioner attitudes and influences on practice** (see Extended Paper, Chapter 1.6)

Research suggests there is little evidence clinicians are actively influenced by research (Milne, Keegan, Paxton and Seth, 2000; Treacher, 1983), consequently the attitudes of practitioners to EBP have been sought, often with a view to improving dissemination and implementation of research evidence.

Nelson, Steele and Mize (2006), conducted two focus groups (with the aim of exploring attitudes towards EBP and the challenges of implementing EBP). Twelve clinicians (from a variety of professional backgrounds) participated; they were employed across two mental health centres in the United States. Questions included “where do you get your information on treatments?” Thematic analysis indicated practitioners did not feel research had a major impact on their treatment selection. They expressed concern regarding the generalisability of research conducted under highly controlled conditions, claiming these failed to account for the real-life complexity of their clients. Attitudes towards EBP varied between the two groups with one viewing it more positively, the other more negatively. Professional role is cited as a potential factor for this difference; future research suggestions include exploring these issues with a more homogenous group of specific professionals. Group members were not provided with a definition of EBP, nor were they asked to provide one; it is recognised that this may influence attitudes towards the model; the researchers recommend future research would benefit from exploring how participants construct the model.

Whereas the previous research focused on aspects of EBP that may affect practitioners’ receptivity to EBP; Lucock, Hall and Noble (2006) considered EBP as one of a potential number of factors that may influence psychological therapy practice. Questionnaires were

administered to 95 qualified psychological therapists and 69 trainee clinical psychologists within the UK. Current and past supervision, client characteristics, formulation and professional training were rated as being the factors most likely to influence clinical practice, across both qualified and trainee groups. Therapeutic orientation was found to influence reported EBP use, with those of a CBT orientation rating EBP higher than those using (predominantly) other therapeutic approaches. The researchers expected EBP use to be rated higher for the trainees, as it was not, they assume that other factors trainees rated higher (such as supervision and current training) will have inherently incorporated EBP. They highlight the questionnaire design to be a limitation due to the inability to explore reasons why such ratings were made; they suggest qualitative research would be useful to explore this further.

Corrie and Callanan (2001) wanted to explore EBP in relation to the SPM. They acknowledged that there is an increasing emphasis on psychological practice being informed by research evidence or being evidence-based within the UK. Furthermore, they state if therapists are to operate effectively within evidence-based services, it is necessary to develop an understanding of the factors influencing their attitudes towards research in routine clinical work. They outline the SPM as being one of the dominant frameworks for guiding practice, and the emphasis within the model on the importance of psychologists being skilled in practice and research (Barlow, Hayes,

and Nelson, 1984). Citing their own work (Corrie and Callanan, 2000) they believe this model has moved from being conceptualised as a single way of working or specific research methodology, to a model which encapsulates more individual philosophies of working.

In order to explore whether therapists believe the SPM competes or complements the EBP ideology and approach to decision-making, the researchers conducted in-depth qualitative interviews with eight therapists. In terms of perceptions of the SPM, many felt the traditional definition of the model was restricting; this related to debates about how the very nature of science is defined and recognition that there are different perspectives within this. Corrie and Callanan (2001) identified three universal themes which mediated participants' outlook and conceptions of EBP and the SPM; their personal value systems, the influence of colleagues in terms of their approach to research and finally the impact of external events such as organisational constraints in being able to conduct research. Corrie and Callanan (2001) suggest further research is necessary to establish whether these themes are applicable to the profession on a wider scale.

### **Recent contextual factors in the UK** (see Extended Paper, Chapter 1.5)

There have been several significant developments within the UK which have impacted the psychological therapies professions. These



include a change in the way parts of the NHS are structured and governed, the development of a new service programme, the publication of a range documents covering various aspects of clinical psychology delivery, and changes in clinical psychology training; these are explored in turn below.

### *Foundation Trusts*

The development of foundation trusts and the perceived change in culture is considered potentially to have the most impact on what clinical psychologists can do in terms of research activity. Such trusts operate according to a business model wherein efficiency, cost savings and value for money are a priority. Such emphasis is likely to impact on the activities of the psychologist, with research not being seen as a priority (Morton, Patel and Parker, 2008).

### *Improving Access to Psychological Therapies (IAPT)*

Evidence from research can influence practice at the level of guidelines for the individual practitioner, through to service development, as Pilling (2008) illustrates; "The emphasis on psychological interventions in NICE guidelines has also had a significant impact on health policy in the UK, with NICE guidelines forming the evidence base for the improving access to psychological therapies programme (Department of Health, 2007, pp. 332)". Arising from the Layard (2006) initiative, its main function is to

increase access to therapy for individuals with mild to moderate depression and anxiety, via CBT and CBT based self-help.

### *New Ways of Working*

The New Ways of Working for Psychologists documents outline the current and future roles of applied psychologists, these cover such areas as career progression and roles (BPS, 2007 a) the training models for applied psychologists (Wang and Burns, 2007), models for organising and managing psychological services (BPS, 2007 b), working in teams (Onyett, 2007), Improving Access to Psychological Therapies (Turpin, 2007) and the Mental Health Act (Taylor, Hanna, Gillmer and Ledwith, 2009). The Improving Access to Psychological Therapies report (Turpin, 2007: 39), highlights as a central aspect the issue of evidence-based practice in psychology (EBPP), while highlighting that “the absence of evidence in relation to an intervention...is not synonymous with evidence for the ineffectiveness of such interventions...applied psychologists have an important role in implementing procedures that will help secure such evidence in the future using appropriate research methodologies”. The report proceeds to highlight the need for mixed methods, stating “a single research methodology cannot build a science of the psychological therapies” (Turpin, 2007, pp. 39). A number of recommendations for research activity are made, including broadening the focus from treatment efficacy to treatment utility (in real-life settings),

identifying common and specific factors involved as mechanisms of change, and evaluating integrative models. A further acknowledgement relates to the issue of diagnosis, and recognition that while individuals may be grouped together according to this label, there is considerable variability between them beyond this, and data needs to reflect this.

The need for practice-based evidence to demonstrate service outcomes is highlighted; this includes the inputting of data at a service level (waiting times, client demographics), individual practitioner level, and individual client level (client outcomes). This data is therefore used to make changes in service delivery at any of these levels, if necessary. The report recognises tensions between these different levels. Specifically advocating a move to broaden the evidence-base encourages research methodologies that may be grounded in epistemological positions which historically have not been recognised within practice guidelines. The move to consider and incorporate a focus beyond diagnosis in research may also support a more service user oriented evaluation.

While there may be individual service level factors which may impede research activity, such services are imbedded in a wider system which may also have its own priorities, pressures and targets. Recent changes within the United Kingdom at this wider system level of NHS Trusts are an example of this.

### *Clinical Psychology Training*

The IAPT programme has fed into the debate around the role and scope of clinical psychology practice. Clinical psychology training emphasises developing a broad skills and knowledge base, with the ability to draw on a number of theoretical models. These core competencies are espoused in the New Ways of Working for Applied Psychologists (Lavender and Hope, 2007). However, in response to the increasing focus on CBT within the NICE guidelines, the Division of Clinical Psychology has recommended training courses ensure trainees are trained to deliver NICE recommended interventions, including CBT (Mental Health Strategies, 2007). Such a move has stimulated debate within the profession; Nel (2009) suggests that as a profession we may want to reflect on the benefits and costs of specialising in one model of clinical practice namely CBT. Gilbert (2009) expresses concern that CBT is being used as a service delivery model, with primary care trusts being concerned only to increase access to one-to-one CBT, and states it is a model of therapy, not a science of mind or a service model. Gilbert (2009) addresses a number of issues in this article, namely that NICE does not support the superiority of CBT over all other interventions; that CBT does emphasise and have an interest in the therapeutic relationship (it is sometimes accused of failing to take this into account); and suggests that rather than just increasing access to one-to-one support, clinical psychologists (from a more community psychology perspective) may

wish to focus their attention on, and develop ways to approach the social causes of distress, rather than simply focusing on reactive strategies and approaches.

### **Summary and Research Aims** (see Extended Paper, Chapter 1.7)

EBP has become a guiding framework within psychology (Turpin, 2007); practising in an evidenced based way entails integrating research with clinical expertise as a basis for clinical decision making. Clinical practice guidelines provide a synthesis of research evidence in specific areas and make recommendations accordingly. These guidelines have been criticised on various grounds, namely that the research included, favours a particular research paradigm, that, rather than guiding practice as they suggest, they have become a means to constrain clinical practice (The Midlands Psychology Group, 2010), and that the EBP model as a whole promotes a very limited perspective on what counts as evidence (Nel, 2010). The SPM has been the most dominant model for guiding clinical psychologists practice in the past; this holds as one of its central tenets the need for clinicians to be adept at both research and clinical practice. The extent to which this captures an accurate description of the work of the clinical psychologist has been questioned over the years (Corrie and Callanan, 2000). The need to understand practicing clinicians' receptivity and uptake of the SPM and EBP models has been identified as an important research area

(Arrons, 2004; Lucock, Hall and Noble, 2006; Nel, 2010; Nelson and Steele, 2006); for several reasons; to establish the extent to which EBP influences clinical practice, which other important factors play a part, whether practitioners consider EBP and the SPM to be synonymous models (Corrie and Callanan, 2001), and practitioner attitudes towards these models. EBP has increasing influence over mental health care services in the United Kingdom; the recent Improving Access to Psychological Therapies programme is one such example. It is therefore an opportune time to explore with trainees who will soon be entering this field, whether these models are considered to accurately capture and reflect their practice, and to explore the aforementioned aspects with them. This research has important implications for future clinical psychology training and practice, and it is important to explore how the next generation of professionals perceive the EBP and SPMs (Dyer, 2008; Luebke et al, 2007; Smail, 2006).

## **Research Aims**

- 1) To investigate how UK clinical trainee psychologists' perceive and construct evidence-based practice and their attitudes towards it.
- 2) To explore how clinical psychology trainees construct the SPM in relation to the EBP model and, as a framework; how it fits with trainees' practice.

- 3) To explore whether recent changes in the context of the delivery of psychological services (i.e. the IAPT programme), has influenced trainees perception of EBP and the SPM.

## **Methodology** (see Extended Paper, Chapter 2)

### **Design** (see Extended Paper, Chapters 2.1

A qualitative approach was deemed appropriate to allow participants' the opportunity to explore the research area in as open a format as possible. Focus group methodology was considered the most appropriate, as this enabled the least restrictive format within which the participant's constructions of these models could be explored in depth. Focus groups are considered to allow researchers to capture the complexity of participants' perspectives (Nelson, Steele and Mize, 2006). Focus group methodology is a way of collecting qualitative data that involves engaging a small number of people in an informal group discussion 'focused' on a particular topic or set of issues (Wilkinson, 2008). The number of participants varies, with suggestions of no more than seven for complex issues, and most authors suggesting between six and eight; although this can range from three to twenty (Bloor, Frankland, Thomas and Robson, 2001; Kitzinger and Barbour, 1999; Krueger, 1994).

The research was approached from a social constructionist epistemological position influenced by the work of Gergen (1985), who suggests there are four common assumptions inherent in most social constructionist work these include; a "radical doubt in the

taken-for-granted world; the viewing of knowledge as historically, socially and culturally specific; the belief that knowledge is not fundamentally dependent on empirical validity but is rather sustained by social processes; and that descriptions and explanations of phenomena can never be neutral but constitute social action which serves to sustain certain patterns to the exclusion of others". (Harper, 2006, pp. 49). This approach or "metatheoretical framework" (Dallos and Draper, 2000), was also informed by the work of Harper (2004), and by its' very nature is conducive to an exploration of this research area.

### **Participants** (see Extended Paper, Chapter 2.3)

Trainee clinical psychologists in their final year, from three doctoral courses in the UK were recruited. Of those approached, a total of 14 were available to participate on the days of the focus groups. All were female (age range 27-45) and were a self-selected sample. Three separate courses were chosen at it was anticipated that each course may have its own stance in relation to EBP and the SPM, which may influence participants' constructions of the models.

### **Procedure** (see Extended Paper, Chapter 2.7)

Following University of Lincoln ethical approval, the course directors of each of the three targeted clinical psychology courses were contacted via email and permission was obtained to contact



their third year trainees. The universities were chosen on the grounds of their geographical proximity. Liaison with administration staff established the most convenient time in the trainee timetable to arrange the focus groups; these times were included in the information sheet for each university. Administration staff forwarded the recruitment email and information sheet to all third year trainees on their course. Contact details were provided and willing participants contacted the researcher via email.

The focus groups were conducted at each university base in the location where trainees attended teaching. The intended number of participants for each group was six; the rationale for this number was in part due to recommendations within the literature (Barbour, 2008; Kitzinger and Barbour, 1999) but also, the researcher was aware of how equally busy her fellow trainees were, and considered six was a feasible amount to be able to recruit considering the other demands the trainees have, not least their own research. However due to a number of factors (e.g. participant ill health) only one group contained the desired six participants, a second group contained five participants and the third group contained three participants.

The focus group questions were developed in part from previous research (as highlighted in the background section), and from my own interests arising from the literature accessed.

### *1) Evidence based practice*

Participants were asked what evidence-based practice meant to them (Nelson, Steele and Mize, 2006). This aimed to explore how participants made sense of this phrase in light of their own practice; and to illuminate how this concept is constructed in the context of the participants' position as trainee clinical psychologists.

### *2) The Scientist-Practitioner Model*

Participants were asked what they understood this term to mean, they were also asked if and how, it related to EBP (Corrie and Callanan, 2001). These are potentially two guiding frameworks which may influence decision making, therefore, exploring them in terms of the role of the clinical psychologist offered insight into how current trainee clinical psychologists conceptualised their role.

### *3) Improving Access to Psychological Therapies (IAPT)*

As a relatively recent development within psychology services, IAPT was raised to elicit perceptions and reactions in light of the potentially changing landscape of psychological services and modes of delivery. This issue has not been explored with trainee clinical psychologists in previous literature. The intended question was open and aimed to invite comment.

Upon arrival to the focus group, participants signed the consent form and completed a demographic information sheet. Participants

were informed that any identifying information in their responses would be removed. The focus groups were conducted in accordance with recommendations by Krueger and Casey (2000). These included creating a warm, friendly environment, arranging the seating in a circle with the tape recorder in the centre, providing a standard introduction, an overview of the topic, and setting ground rules. Pauses and probes were used to facilitate quieter members, (such as enquiring if the rest of the group shared a stated opinion; asking if a person's silence was due to agreement or a different opinion); at the end the researcher summarised and asked if anything has been missed.

The groups were conducted between October and November 2009 and lasted between 45 and 75 minutes (guided by the time participants had available, one group was held during the lunch hour). At the end of the group participants were thanked and any questions answered. The groups were audio-taped using a dictaphone and later transcribed verbatim by a paid transcriber. The transcription conventions employed were relatively simple, as the in-depth transcription required when using conversation or discourse analysis are not necessary for thematic analysis (Braun and Clarke, 2006). Briefly, each transcript was given a label of F1, F2 or F3 (these denote the order in which they were conducted, focus group 1 etc). Three ellipsis points at the start or end of an extract indicates overlapping speech, three ellipsis points within an extract indicates a

pause, and three ellipsis points within brackets indicate where some text has been removed for ease of reading; text in brackets indicates other forms of communication that may be occurring within the group such as (laughter), or other utterances (mmmm).

### **Method of analysis** (see Extended Paper, Chapter 2.9)

The resultant transcripts were checked and amended where necessary. Focus group data can be analysed in a number of ways which is largely determined by the theoretical framework, research questions and aims. Webb and Kevern (2001) highlight the lack of attention to- or inconsistency with- the epistemological position of the researcher and the analytic method used in focus group research. Several methods were considered for this research, which can all be approached from a social constructionist perspective; such as grounded theory (Strauss and Corbin, 1990), discourse analysis (Potter and Wetherell, 1987), narrative analysis (Murray, 2008) and thematic analysis (Braun and Clarke, 2006).

Narrative analysis is often used when exploring individuals' experiences (such as ill health, or trauma) and may focus on identity and self-construction (Crossley, 2007). This approach was not felt to be the most appropriate for this research as it did not fit the research questions; rather than being about a particular event or experience the participants were reflecting on certain concepts. Grounded theory

was also considered, but as the research aim was not theory development, this approach was discounted.

After carefully considering the above approaches and through discussion with the research supervisor, Thematic Analysis (TA) was chosen as the analytic method due to its flexibility, both in how it can be applied and in not being wedded to a particular theoretical/epistemological position. Thematic analysis is a method for "identifying, analysing and reporting patterns (themes) within data" (Braun and Clarke, 2006, pp. 79). This method "at the minimum describes and organises possible observations or at the maximum interprets aspects of the phenomenon" (Boyatzis, 1998, pp. vii). There has been some debate about what TA is and how it is best carried out (Attride-Stirling, 2001). Braun and Clarke (2006) present a paper outlining the theory and method of TA, which forms the basis of much of the following description.

The analysis followed the recommendations by Braun and Clarke (2006), who have described six phases of thematic analysis; this is a cyclical as opposed to linear process. This is illustrated in table 1 (adapted from Braun and Clarke, 2006, pp. 87).

**Table 1** Phases of thematic analysis

Phase	Description of the process
1. Familiarisation with data:	Transcribing of data, multiple readings of data, initial notes made.
2. Generating initial codes:	Code interesting features of the data in a systematic way, across the whole data set, collate data relevant to each code.
3. Search for themes:	Collate codes into initial themes; gather all data relevant to each theme.
4. Review themes:	Check if all themes work in relation to the coded extracts, and entire data set, generate a thematic 'map' of the analysis.
5. Define and name themes:	Ongoing analysis to refine each theme and the overall story the analysis tells, generate clear definitions and names for each theme.
6. Produce the report:	Select relevant extract examples and relate back to the research questions and literature.

**Evaluation** (see Extended Paper, Chapter 2.11)

The issue of how to evaluate qualitative research is complex; the traditional criteria of objectivity, reliability, validity and generalisability associated with quantitative research may not be appropriate. Elliot, Fisher and Rennie (1999) have outlined a number

of criteria for qualitative research, with a threefold aim of legitimizing qualitative research, of fostering more valid reviews of qualitative research and to assist in the development of good qualitative research. They suggest seven criteria for qualitative research specifically which includes; owning one's perspective; grounding analysis in examples, providing credibility checks, coherence, and the report should resonate with the reader. Guidelines for qualitative research have been met with a mixed response, with some perceiving such a move as failing to acknowledge or do justice to the diversity of qualitative research (Barbour, 2001; Golafshani, 2003; Madill, Jordan and Shirley, 2000; Winter, 2000). Researchers who favour a particular analytic approach have often developed their own recommendations for how their research may be evaluated, often relating to an assessment or judgement of the overall consistency and coherence within the research. Braun and Clarke (2006) present a 15-point checklist of criteria by which thematic analysis may be judged, however, they do not describe this in a prescriptive manner and recognize other researchers may wish to expand or alter this. Essentially, they also refer to the overall consistency within the research project and a thoroughness to the analysis (refer to Braun and Clarke, 2006, pp.96 for the checklist). The researcher consistently referred to this list throughout the research process; following their recommendations from checking the transcripts against the tapes for accuracy, to ensuring each data item was given

equal attention, to ensuring the researcher is positioned as active in the research; the themes do not 'emerge' they are created by the researcher. The themes generated were discussed with the research supervisor; a process that was intended to increase the consistency and coherence of the analysis. This was not considered in terms of inter-rater reliability but more of an opportunity for the researcher to justify her interpretation of the data, this also operated as a form of triangulation. This also functions as a form of peer review (Cresswell, 1998).

**Reflexivity** (see Extended Paper, Chapter 2.12).

In qualitative methods the reflexive element is closely tied to evaluations of validity (Antonacopoulou and Tsoukas, 2002). In making the researchers' influence in all its forms explicit, this may attempt to address concerns about the validity of knowledge claims and inform a study's credibility (Schram, 2003); the researcher attempted to illustrate her position throughout the research in order to address this. Epistemological reflexivity requires the researcher to reflect on the epistemological assumptions they approach the research from, but also to state these explicitly and consider how such a framework has shaped what they have found. Personal reflexivity involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research (Nightingale and



Cromby, 1999, Rolls and Relf, 2006); for instance it is important for the researcher to acknowledge that she too is a fellow trainee clinical psychologist along with the participants, who also is trying to make sense of these models in light of her practice. Consequently it has been important for the researcher to ensure the themes created are firmly grounded in the transcripts.

### **Results** (see Extended Paper, Chapter 3)

The results are presented in three sections. The first section details the themes developed in relation to EBP, these are presented in table 1. This follows with a description of these themes and accompanying extracts to illustrate. This is followed by a summary of the themes connected to the concept of the SPM, an outline of these are in table 2, again with further elaboration and quotes. Finally, the themes created to capture responses to IAPT are tabularised (table 3) and described.

**Themes related to EBP** (see Extended Paper, Chapters 3.5, 3.6, 3.7, 3.8, 3.9).

#### ***Question 1: What does evidence based practice mean to you?***

Responses to EBP were separated into two separate thematic maps, the first related to concepts of evidence (with three sub-themes), the second reflected attitudes towards EBP (with two sub-themes).

**Table 1 Focus group themes in relation to EBP**

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**Focus Group question:** What does evidence based practice mean to you?

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**Group themes:**

**1) Evidence**

- i. Research evidence (RCT & quantitative, Case study & qualitative).
- ii. Therapist evidence (Accumulative experience, Clinical Judgement, Intuition).
- iii. Client Evidence (Feedback, self-report).

**2) Attitudes**

- i. Utility of EBP (ethical practice, guides resources; provides containment for trainee).
- ii. Limitations (presents simplistic and restrictive view of practice, neglects influence of supervisor)

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*Theme 1: Research evidence*

Initial responses referred to evidence in terms of quantitative methods:

*I think it's a lot of efficacy research I think informs evidence based practice so the very controlled RCTs that show a specific model to work for a specific client group and disorder (F3: 15-18).*

*I think my initial thought, probably because of the course, is kind of randomized control trials, big budget research as though that is the pinnacle of evidence based practice...*

*...almost the only acceptable... (F1: 5-8, 17).*

This was participants' initial response to the concept; however, they felt other sources of evidence informed their practice:

*although from a personal point of view I think it would incorporate a lot more than that (F1: 8-9).*

These expanded definitions incorporated more qualitative forms of research. There was the sense that conceptualisations of evidence had changed, and that there may be a number of ways of constructing it.

*Basically em, like a sort of scientific paradigm which says this is how you get proper evidence, this is the way and this is this, and sometimes things like NICE guidelines will only take into account things from that particular paradigm, whereas within psychology I think there is new ways of thinking about things. So like for example thinking more reflectively, thinking more about like what's working, more person centred perhaps em (F3 221-230).*

Participants seemed to see evidence as a broader construction which included aspects the therapist brings with them; the codes which referred to such therapist factors were incorporated within the next theme, therapist evidence.

## *Theme 2: Therapist Evidence*

The therapist was considered to be a source of evidence in their own right.

*I just think your own experience obviously then gives you your own evidence, you know of what might work, but that's really difficult to quantify, like you say everybody's experience is completely different as well but its such an important part of what you bring. (F2: 310-316)*

This direct experience of adapting practice in relation to on-going learning was considered to be a form of practice-based evidence, establishing the effectiveness of an intervention with this particular client, in this particular context.

## *Theme 3: Client Evidence*

The client as a source of evidence was the final aspect related to evidence:

*getting the feedback is the evidence (F3: 113).*

Qualitative research was conceptualised to be more 'formal' evidence, whereas client evidence related to in session feedback and self-report, and was a more immediate guide for the therapist.

*If the self report is negative, then you know where you are, you know that more's needed or perhaps the approach hasn't been right (F2; 775-779).*

This appeared to link back to the need for participants to observe change first hand, this seemed to have more weight and credibility than research recommendations, which seemed to be viewed as abstract and distant from actual practice. However, this was not considered to be consistent with current dominant conceptualisations of valid evidence:

*Why can't, why don't we listen to service user feedback, why is the client satisfaction questionnaire not deemed you know, science, research or evidence based? (F1: 949-952).*

#### *Attitudes to EBP*

The second part of the themes related to EBP concerned attitudes towards EBP. An over-arching moderator that tempered participants' attitudes was the definition of evidence used. When participants were describing their responses to EBP it became clear they were using the 'research' construct of evidence, as opposed to the other two areas they had also identified as evidence (client and therapist evidence). Positive attitudes toward EBP referred to being open to EBP and perceiving it to be a good starting point:

*I personally think that evidence based practice is a good thing, but it's got its limitations and it's not just the whole, it's some of part of what other things that can be done that's useful (F2: 188-193).*

EBP was also considered in terms of its utility in terms of promoting ethical practice:

*I agree with (name) that evidence based practice is an important part of our work because I think it's unethical to just go doing something willynilly based on nothing. (F2: 249-254).*

It was also considered to have particular utility for clinical psychology trainees, who felt it offered them a source of containment:

*I think whilst you're training probably, it's probably, it feels safe and secure to perhaps follow guidelines and follow models (F2: 327-330).*

In regard to the perceived limitations of the EBP model, these related to a questioning of the underlying drivers behind some of the evidence:

*I think the more you hear about the NICE guidelines and the drivers and the commissioners for the NICE guidelines and all funded by the drug companies aren't they a lot of them, and what we know about how easy it is to evaluate CBT versus other therapies, you kind of think well its no wonder they're in it (F3: 544-550).*

There were a number of perceived limitations of the EBP model some of which concerned feeling like it dictated practice:

*I think it feels much more prescriptive and less joint working, and less collaboration and just applying pure research to the*

*situation and not taking into account all the other variables (F2: 499-505).*

Participants also considered the role their supervisor played in influencing their practice, as well or instead of the evidence base:

*I think it's really difficult because, particularly at this level, we pretty much, to an extent, work how our supervisors want us to in a sense. So if your supervisor's very stringent on you working to NICE guidelines then you do that. But if your supervisor never mentions NICE guidelines will you refer to them or not? (F1: 1368-1374).*

The researcher considered there were several ways deference to the supervisor over the 'evidence-base' could be interpreted; this was formulated as partly a question of power, but also in terms of proximal and distal factors. Supervisor feedback has been rated as highly influential on practice by both qualified and trainee clinical psychologists (Luckock, Hall and Noble, 2006). Trainees may be led by more proximal factors; the supervisor is aware of client characteristics and formulation, their advice may be more tailored to client needs, trainee competence and experience; and be considered as more context specific (geographical locales, awareness of immediate contextual factors). As has been cited in the background literature, evidence-based recommendations and guidelines are often perceived as not being generalisable to real-world conditions; this

may be because they are seen as distal in that they are removed from the current situation.

**The Scientist-Practitioner model** (see Extended Paper, Chapter 3.10).

***Question 2: What does the scientist practitioner model mean to you?***

The second area covered within the focus groups was the scientist-practitioner model; the main themes are presented in table 2: There were four main themes considered to capture the groups' discussion relating to this model, these were; the SPM as 'potentially restrictive,' 'research', 'creative thinking', and 'the scientist as practitioner'.

The first theme related to the potential for the model to be restrictive. Participants considered this implied working from a 'top-down' approach; applying theory and research to clients, as opposed to a 'bottom-up' approach, where the client led the treatment (these concerns were similar to those expressed in relation to the EBP model).

*I don't think that the idea of evidence based practice and scientist-practitioner is a bad thing, I just think if you apply it really rigidly without thought it can be quite a bad decision (F2: 562-568).*



**Table 2 Focus group themes in relation to the SPM**

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**Focus group question:** What does the SPM mean to you?

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**Group Themes:**

**1) Potentially restrictive**

- i. Negative view if model imposed

**2) Research**

- i. Conducting
- ii. Utilising
- iii. Accessing
- iv. Disseminating

**3) Scientist as practitioner**

- i. Ability to evaluate
- ii. Hypothesis testing in therapy

**4) Creative Thinking**

- i. Flexibility
  - ii. Adaptability
  - iii. Reflexivity
  - iv. Enquiring outlook
-

The second theme covered the research aspect of the model. This included actively carrying out research, making use in practice of research findings, actively searching the evidence base and circulating research.

*I can see it as someone who will draw on evidence but also theory to inform the approach and actually use your framework of psychological reference, that is theory and evidence based to inform your work and being driven by that (F3: 780-784).*

*there's something about in our role bridging that gap of making evidence more accessible not just to psychology but to everyone so that it becomes more common practice but at the moment it's sort of set apart isn't it within these little journals (F3:972-977).*

The third theme 'scientist as practitioner' encapsulated the ideas and ways a scientist practitioner was considered to approach their practice:

*I think of it in terms of just applying a scientific way of thinking about somebody, so I guess the whole hypothesis, testing, you know not just coming up with a formulation and thinking that's my formulation and I'm going to go with it because I think that's what it is, but actually being a bit more rigorous about it and testing that out in light of evidence (F2: 413-424).*

This theme reflects a perspective found elsewhere in the literature, that the SPM reflects an attitude to practice and is not necessarily restricted to a focus on publishing research, it also postulates that there may be more than one way of conceptualising the scientist practitioner (Kennedy & Llewelyn, 2001); but also that part of being a scientist practitioner is about being reflective.

*To have an open and enquiring mind I guess (F3:812).*

*thinking more reflectively, thinking more about like what is working (F3: 228-229).*

The final theme, creative thinking, brought together the perceived strengths of the role, including approaching things with curiosity, being adaptable and reflecting on theory and practice.

**Improving Access to Psychological Therapies** (see Extended Paper, Chapter 3.11).

***Question 3: How does IAPT fit into current practice?***

The final area of discussion within the focus groups concerned the IAPT programme. This topic brought in many initial data codes and subsequent themes, the researcher tried to make sense of these by organising them into two over-arching themes of 'Threats' and 'Implications of CBT emphasis', this seemed to capture the essence of

the content which related to the perceived impact of IAPT (see table 3).

**Table 3: Focus group themes in relation to IAPT**

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**Focus group question:** How does IAPT fit into current practice?

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**Group themes**

**1) Threats**

- i. Economic factors
- ii. Dominance of the medical model

**2) Implications of a focus on CBT**

IAPT was perceived as presenting a number of threats such as economic factors, this related initially to the perceived political drive behind IAPT of returning people to work:

*they have been very very selective in their target client group as such, but yes I suppose that's the fundamentals of IAPT (lots of agreement). But that's again it's the economy, those are the people working, If the economy isn't, those are the people working .... back into the system, it's that cost, you're going back to cost effective (F1: 789-797).*

This was seen as a threat in the sense that cost-effectiveness is a motivating factor for the creation of IAPT as opposed to purely being motivated by a public health initiative; it was considered a threat as

this motivation undermined receptivity to it. The economic aspect also incorporated consideration of the impact of employing psychological therapists who cost less than clinical psychologists, which was perceived as a threat, leading to a need to justify our wage.

*how can we sort of justify ourselves if they can pay somebody less to do that, that's the worry I think for a lot of psychologists (F3: 729-732).*

This sense of threat relates to the next theme, the medical model, which equally may have a very different conceptual framework from a psychological one.

*where's that scientist practitioner you know, we're not allowed to reflect we have to follow that medical model yet again as we do with all the classifications, the mental illnesses or whatever (F1: 512-515).*

*I think it's partly the medical model about there being an ultimate cure as well (F2: 929-931).*

The final theme, considering the implications of the emphasis on CBT in IAPT, was felt to limit client choice and suggest a standard as opposed to individually tailored approach; in this sense the IAPT model may not emphasise a formulation driven approach:

*you lose the person centred approach so it's fitting the square into a circle, you know that client will fit into that model regardless (F1: 150-152).*

Participants reflected on the potential impacts of EBP and IAPT and how it related to their professional role. Consideration was given to the SPM and how this concept defined or guided their practice. The interrelatedness of these aspects, and the psychologists' position in a health care system caused some to reflect on the future role of the clinical psychologist.

*I think it's important we do research...it's a key part of our role...maybe talk to commissioners about that side of your role and sell yourself as doing that as well. (F3: 836-837/852).*

## **Discussion** (see Extended Paper, Chapter 4).

The aim of this research was to explore with trainee clinical psychologists, their beliefs about EBP and the SPM in the context of the recent IAPT development. By using focus groups the research aimed to explore participants' constructions of these concepts in relation to their practice. Thematic analysis was used to create themes the researcher considered organised and described the data.

Previous research in this field has indicated that practitioners hold various beliefs about EBP; how they construct the model has been found to influence their receptivity to it. For those who conceive

EBP to be the implementation of clinical practice guidelines; research indicating practitioners do not implement recommendations arising from such guidelines, is interpreted to indicate that they therefore do not practice EBP (Dawes, 1994; Hoagwood and Olin, 2002). Research exploring factors influencing guideline uptake, highlight practitioners perceive the research upon which these are based, as lacking ecological validity, as the controlled conditions within RCTs are considered to be unrepresentative of those seen in everyday clinical practice (Adams, 2008).

The findings from the current study indicate that participants conceive EBP to be primarily efficacy research arising from RCTs. This finding is consistent with previous research (Luebbe et al, 2007). Participants considered EBP, when defined solely in these terms, as presenting a simplistic and restrictive approach to practice. However, in contrast to previous research (Hoagwood and Olin, 2002), participants own construction of what they considered EBP should be, was that it should incorporate research evidence derived from various research methods. Participants reported they may refer to guidelines but (unlike Dawes, 1994) they also consider 'evidence' as deriving from their supervisor, from their own clinical experience and from the client. The current study provides a valuable contribution to the EBP field as interestingly and somewhat ironically, the elements participants considered should be included within the EBP model (research plus client and therapist factors) are consistent with the

actual APA (2006, pp.273) definition; ("the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preference"). This finding is important for those who wish to promote the EBP model as it would indicate that for these participants, their initial perception of the model is inaccurate. A recommendation for advocates of the model arising from this finding, may be that to increase receptivity to the model, promotion of the model and highlighting how it links to current practice may be all that is required to encourage its adoption.

However, participants also identified their supervisor as a further source of guidance they draw on, as part of their decision making regarding the most appropriate intervention. For participants this may relate to their position as trainees, for whom greater guidance and direction may be necessary to further their development. This finding may indicate the role supervisors have in promoting and encouraging their trainees to search and appraise the research evidence. Participants in the current study stated they had varied experiences on placements with some supervisors referring to NICE guidelines for example, while others did not make reference to them or the wider research. There may therefore be a recommendation for supervisors who can facilitate discussions with trainees about pertinent research, and the role of guidelines, and further expose them to various perspectives on these issues.



The current study further adds to the existing research on EBP by highlighting that (for at least the trainee clinical psychologists in this study), evidence is not conceived of as being restricted to efficacy and RCT research, but that other research methods and questions also produce equally valid and relevant forms of evidence and knowledge. The call for the definition of evidence to be expanded (to include the findings derived from qualitative research as well as therapist and client factors) was highlighted within the focus groups, and within the wider literature. The New Ways of Working (NWW) (Turpin, 2007, pp. 39) documents further support such a move and in part address and highlight a common criticism which is directed towards the research evidence base (that it privileges a certain paradigm), by stating that: "A single research methodology cannot build a science of the psychological therapies. The diversity of human nature requires diverse research designs...(and) although primary emphasis is currently placed on data focusing on treatment efficacy (i.e. does a treatment work), there is increasing need for an equivalent focus on clinical utility (i.e., the applicability, feasibility and usefulness of the intervention in the settings to which it is to be offered)". While participants indicated such a move was desirable and necessary, they expressed reservations about the possibility of conducting further research themselves; partly due to reluctance, (having found their thesis to be a stressful and aversive experience); and partly doubt as to whether future employers would value such

activity and allocate time available for this. However, the significance of research in their role as clinical psychologists was considered paramount in relation to the SPM.

There were similar themes created around both the EBP and SP models. The SPM was also perceived as being potentially restrictive, which influenced receptivity to the model. It was constructed as a model which advocated prescribed practice, in that participants considered it to recommend applying research to practice without a consideration of whether such evidence was applicable to each individual context. However, the findings contribute to the existing research on the SPM by suggesting that, for at least these participants, their construction of the SPM has moved away from this 'official' definition or version. Participants considered the model included drawing together research (from all methods) with client and therapist factors, but doing so within a critical and reflective framework. The critical-reflective-scientist-practitioner (CRSP) model was the term created to capture the various themes constructed around this area. Participants considered the CRSP as someone who conducts and draws on all forms of research (both qualitative and quantitative), takes a critical approach to their practice (in that they would take a questioning stance of both theory and research); but also a reflective position in that they expect to continually examine their practice and develop and grow as a result. This was contrasted with the perception of the 'narrow' version of the EBP and SP models;

which participants considered view practice arising from a research recommendation as being, 'apply x treatment to y disorder', without taking into account the applicability of the research, or client or therapist factors (or alternative conceptual frameworks which may question the construction of 'disorders' and psychiatric diagnoses). Participants considered the CRSP was central to their professional identity and helped distinguish them from other psychological practitioners. The findings may suggest the SPM has evolved in response to the ever changing context of clinical practice.

The IAPT programme and the NICE guidelines have become prominent in the debates within the profession about the role of EBP and the SPM. If the scientist-practitioner is adept at research evaluation and is an adaptable and flexible, autonomous practitioner, then practice is influenced by relevant research, client factors and therapist experience. The driving force behind the scientist practitioner model is a 'bottom-up' client led, formulation informed intervention, with research evidence informing the most appropriate intervention. Whereas, a diagnosis led model is a 'top-down' approach; a diagnosis may (frequently) lead to the recommendation for CBT irrespective of the needs of the client. While this is a very simplistic outline of IAPT and NICE, this seems to be the underlying assumption as perceived by the participants; this would seem to be akin to pushing two opposing magnets together, with the conceptual framework of clinical psychology and the CRSP, and the economically

driven NICE/ IAPT as the two sides. The development of the IAPT programme has not only led to concern around professional boundaries (Morton, Patel and Parker, 2008) but has also (in the case of these participants) caused them to question how they can practice in line with the CRSP (which includes utilising a variety of therapeutic approaches), in a context which emphasises or is designed around a medical framework of understanding.

In summary, the trainees in this research perceived EBP and the SPM as being potentially restrictive for their practice, this stemmed from the perception that these models promoted a view of practice that is primarily based on certain types of scientific research, to the neglect of therapist expertise and client factors. Newnes (2004) has described similar tensions that these dialectics cause; between the scientific stance (looking for generalities and lawfulness) and the clinical stance which stresses human individuality; or put another way, between nomothetic (commonalities) vs. ideographic (which emphasises uniqueness). Participants described an 'official' construct of these terms which was considered to be an autocratic approach. However, this was contrasted with a personal view which was more client and formulation led (or ideographic); this version was connected to the concept of the SPM as being a researcher within their clinical practice as well as an active consumer and producer of research. This version of EBP and the SPM was considered to

incorporate a critical and reflective approach and more accurately reflected how these trainees reported they practised currently.

### **Research Limitations** (see Extended Paper, Chapter 4.2.1)

As in most research, recruitment can be a major source of difficulty. Within the present study one of the limitations may relate to one of the focus groups only having three participants (while this is still considered a viable amount within the literature, with the number of participants recommended at being between three and ten (Kitzinger and Barbour, 1999) and with Bryman (2008) stating a focus group is a method of interviewing that involves more than one interviewee). However, this focus group still had a stimulating conversation with a variety of views expressed and the number of participants was not felt to have limited the group. In an ideal situation (with more relaxed time constraints) it may be possible to delay conducting a focus group until the desired number of participants have confirmed; however, this was a useful exercise highlighting the difficulties of conducting research with such constraints.

### **Research Strengths** (see Extended Paper, Chapter 4.2.2)

The use of focus group methodology addressed the limitations of previous research; the dynamic discussions enabled participants to consider the various factors that both influence their constructions of

the models and explore their influence on their practice; this has been missed within previous research utilising questionnaire methodology.

A further strength of the research includes its' very timeliness; in a recent article Nel (2010, pp. 7), summarised developments over the past decade and included as the eight most prominent ideas; "the end of a postmodern era, the rise and rise of evidence-braced practice, competency-based training, improving access to psychological therapies, professional regulation, increased service user involvement, the expansion of clinical psychology and target-driven waiting times". In referring to EBP Nel (2010, pp. 7) continues; "this enthusiastic programme of legitimisation and application of bio-medical research methods in social sciences has, with few exceptions, proceeded unabatedly. Debates around what counts as evidence and what interests different evidence supports and denies have largely been marginalised"; arguably this research can feed in to such debates and in contrast to Nel's (2010) perspective, the current study would suggest that such debates are still prominent.

As highlighted previously the increasing focus on EBP elicits fervent commentary both for and against, one such response from Coles (2011, pp.23) states "The naive espousal of 'evidence-based' knowledge has meant the voices of those experiencing distress and unusual experiences has been sidelined as a second rate form of

knowledge, to be patronised but not seriously acted upon (see Borg et al, 2009)"). The findings from this research would suggest the converse, that participants wholeheartedly place the clients' perspective as central in their work. Such a statement from Coles (2011) may reflect unfamiliarity with the APA (2006) EBP definition, representing a similar assumption to that of the participants. The current study's findings would therefore support the need for a wider discussion within the profession about the tenets and implications of the EBP model.

The current study highlights that EBP as a term may be discussed but not defined, within both psychological discourse and the wider health system and beyond, (in other words the reader is assumed to know what is being referred to, as though it is a fixed entity). The fact that there is this assumption, and that research in this field indicates there are many constructions, and subsequent attitudes to the model (as highlighted within the focus groups), may indicate that there needs to be a greater discussion about this term and exploration of (to use a Barthesian term), the relationship between the signifier and the signified (Barthes, 1972). The current study extends previous research in this area (Luebbe et al, 2007) and indicates that; how the model is constructed influences receptivity to it, that there is confusion around what the model promotes (Wilson et al, 2009), and uncertainty about whether the model is consistent with

the role of the clinical psychologist as a critical-reflective-scientist-practitioner.

The findings from the current study contribute to the existing research around the SPM, and suggest that, rather than being an outdated term which no longer captures the work of the clinical psychologist (Head and Harman, 1990); at least for the participants within this study, it is a term which is central to professional identity. The development of the IAPT programme and the focus on providing CBT within this was considered by participants, to cause them to reflect on their role, the skills they possess and what distinguishes them from other psychological practitioners. The increase in psychological therapists providing CBT was initially considered to represent a threat to the profession; however, participants considered their training enabled them to draw on a range of models, which was a strength of the role. The emphasis on CBT within guidelines and IAPT was considered by participants, to minimise or undermine their skills as a CRSP, in having an intervention determined a priori. A recommendation for future research may be to explore with those working within IAPT services, the influence of guidelines on their practice, this may highlight whether the participants assumption above, is borne out. However, participants also expressed concern that in drawing on broader types of 'evidence' (and therapeutic approaches) to inform their practice and decision making, these wider forms of evidence would not be considered



'acceptable' within the dominant conceptualisation of EBP. There are clinical implications of these findings which are discussed below.

A further strength concerns the usefulness of the research for the participants; feedback from members included that it had stimulated their thoughts and that they hadn't realised EBP and the SPM connected to so many aspects of their practice:

It's interesting it throws up a lot of questions doesn't it? (F3: 935-936)

I didn't think it would be possible to speak this long on Evidence- Based- Practice (Laughter) – but actually it's really interesting. (F2:1045-1048)

It connects into all kinds of stuff really... (F2: 1050-1051)

**Clinical Implications and future research** (See Extended Paper, Chapter 4.3, 4.4, 4.5)

Recommendations arising from the current study, in addition to those highlighted above, are considered, followed by further recommendations for future research.

### **For clinical psychology training courses**

The findings from the current study have a number of implications for training. That trainees' perception of the 'official' definition of EBP as being restricted to efficacy research is interesting, in that were they aware of the APA definition, which includes therapist experience and client factors, they may be more open to the

model. Participants, as well as highlighting client and therapist factors, also advocated an expansion of the types of research evidence considered acceptable. The question of whether the evidence participants draw on to inform their decision making would be considered valid or acceptable, caused concern amongst participants. One possible recommendation arising from these findings may be for training courses to include teaching on EBP, including the numerous debates which encompass it. These findings support the need for such training as suggested by Harper (2004), who actively promotes the inclusion of social constructionist teaching, and suggests this may enable an examination of concepts which may be taken for granted or assumed to be 'truth' within the wider mental health field; such as the concept of 'evidence'. The exposure to such teaching may enable trainees to feel more confident in the rationale and 'evidence' informing their decision making (Johnstone, 2010).

A further recommendation may be that courses include teaching on the SPM, including how it may be compatible with EBP and the potential differences; this may also facilitate a more informed perspective on two of the models which influence and arguably shape the profession (Collins, Leffingwell, and Belar, 2007).

Training courses may wish to consider the quantity of teaching which relates to more complex presentations where the use of more integrative methods may be warranted. Participants in the current study indicated they often drew on a number of models, but

expressed uncertainty about how this would be perceived. Increasing teaching in these areas may increase trainees' confidence in utilising their knowledge and skills when intervening in situations for which there may be little research evidence.

### **For practitioners**

A recommendation arising from the current research, particularly for those clinicians who offer placements to trainee clinical psychologists, may be that supervisors consider their own conceptualisation of the EBP and SP models and the role of research within these. Participants indicated they are often influenced by their supervisor, in terms of whether they refer to NICE guidelines or not. It may be that supervisors can also contribute to trainees' awareness of differing perspectives on evidence, and provide them with the valuable experience of observing through discussion, the supervisors' process of decision making and the factors considered within this.

### **Future research**

Mace and Moorey (2001, pp. 10) also acknowledge that "scientific evidence' does not exist in some isolated intellectual space but in a social and political environment where it can be used and misused for many purposes". Future research may wish to explore how the EBP has come to be such an influential model.

A further area suggested by the research may be to explore with psychologists working in services which have incorporated an IAPT service, if and how their work has changed following the inclusion of IAPT, and their responses to this.

Related to the above aspect, it may also be interesting to explore whether clinical psychologists have ever had their decision making questioned if they have implemented an intervention which was not recommended within NICE; and what the implications of this were. This may potentially contribute to the EBP field and explore whether (as the participants perceived) research evidence is, in practice, given primacy over the other two elements of the model (client and therapist factors).

A further research recommendation arising from the current study may be to establish the amount of training in these areas across the various training courses, the rationale for this and trainees responses to such training.

A final recommendation may be to explore whether the views expressed by these participants are representative of other trainees across the UK.

**Word Count 1: excluding references and referrals to extended paper): 1004**

**Word Count 2: 11037**

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## **Extended Paper**

### **Chapter 1: Extended Background**

#### **Chapter 1.1 Introduction**

Psychological therapists are increasingly being encouraged to follow an evidence-based-practice model. The following literature review aims to: Explore what is meant by this term; summarise the debates that have stemmed from the increasing emphasis within mental health policy to follow this model; consider other influences that impact on decision making and practice within psychological therapies, including the scientist-practitioner model; and outline recent contextual changes which have caused some in the psychology profession to call for a renewed debate on the aforementioned matters; the Improving Access to Psychological Therapies programme.

#### **Chapter 1.2 Evidence-Based Practice (EBP)**

EBP was initially promoted within medicine and was defined as: "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes, and Richardson, 1996, pp.71-72). One of the sources of contention with the EBP model, or 'movement' as the APA (2006) refers to it as; is the question of what constitutes 'evidence'. Stuart and Lilienfeld (2007) cite as a flaw of the APA (2006) paper, the failure to "operationalise evidence" (pp.615). While the APA (2006) definition above does acknowledge the importance of clinical expertise and client factors, there is a perception among many that the research element is emphasised in clinical practice guidelines above the other two aspects; this will be explored further below.

As stated above, the recommendation that practice decisions should be evidence-based is not confined to psychological therapies; EBP has become a main driver behind many disciplines (Gibbs & Gambrill, 2002). It has been suggested that the primary function of implementing EBP is to facilitate “a cultural change within health care services, resulting in practitioners making conscious, explicit, and judicious” use of current best evidence in their practice with patients (Mayer, 2004; pp.685). This purported function of EBP has been questioned on a number of grounds such as, what is driving this cultural change, what was the pre-existing ‘culture’ and how do the two differ? Who decides what ‘best evidence’ is, and by what standard is this measured? What is the desired outcome of increasing the use of ‘evidence’? These questions constitute part of the EBP debates and will be explored below.

The remainder of this chapter will outline the reported aims of EBP; will describe the means by which evidence based recommendations are disseminated in the form of clinical practice guidelines, and will provide a brief consideration of the impact differing epistemological perspectives have on the concept of evidence and the evaluation of research.

#### *EBP aims to encourage uniformity of practice*

The desire for less variation in practice and an increase in standardisation has a number of proponents; EBP in this sense is seen as an attempt to address the “unacceptable and indefensible” diversity of routine clinical practice (Peckham, 1991). Benjamin (2005) notes how clinicians have been criticised on the grounds that their practice is rarely based on scientific evidence. Dawes (1994) supports this view and claims clinicians should only practice what is proven by research evidence (Nathan, Stuart & Dolan, 2000; Sandelowski, 2004). While this in itself may not appear overly

unreasonable (although some would argue that this hinders the use of innovative practice and the development of new approaches; Adams, 2008), its impact depends on whether the concept of evidence is restricted to a particular conceptualisation of what evidence is, as illustrated above. While there are practitioners who advocate standardised practice, there are those who feel such an approach is too prescriptive (Sehon & Stanley, 2002), and that to follow such a position actually represents a mistrust of clinical judgement and expertise (Hampton, 2002). This may undermine the process of assessment and formulation which leads to tailored interventions, which have been considered to be more effective than standardised ones (Gibbs, & Gambrill, 2002; Rake, 2008).

#### *EBP aims to increase accountability*

EBP is, by some, viewed as an attempt to produce a cultural change which creates a dichotomy between opinion-based actions and evidence-based actions, with a desire to replace the former with the latter (Hampton, 2002). Clinical Judgement is perceived as affording less weight in clinical decision making compared to research evidence and practice recommendations (Miles, Hampton & Hurwitz, 2000). Many authors question the assumption that treatment decisions should be based primarily on research findings, instead suggesting clinical judgement should guide clinical practice (Levant, 2004) or at least be given equal weight (Hunsberger, 2007).

Some of the criticism of clinical judgement relates to the lack of uniformity across clinicians; the assertion that various biases may affect judgement; and that the criteria for expert decisions are considered to be unobservable, which returns to the issue of transparency and accountability in decision making (Beutler, 2004; Cooper, 2006; Dana & Thomas, 2006; Garb, 1998; Guyatt, Meade, Jaeschke, Cook & Haynes, 2000; Hastie, 2001; Shanteau, Weiss,

Thomas & Pounds, 2002). Bauer (2007) suggests research focusing on clinician and client factors in relation to decision making is an important area in order to address some of the above concerns. Examples of this include how do clinicians with varying levels of experience decide which 'treatment' to use in practice? And how does this impact on client outcomes? (Ilardi & Craighead, 2006).

If the EBP movement represents a change in culture this may be interpreted in several ways; if there is an increase in standardised practice this implies there is a 'correct' way of responding to a particular issue, if there is a correct way deviance from this may be questioned, which links into the question of accountability (Bauer, 2007). Standardised practices can be monitored and adherence and compliance fit with a clinical audit and governance framework and culture (Denzin, 2009). While this may have the overarching aim of improving practice and the quality of health care services (Spring, 2007), it has raised concerns among some in the psychological therapy field who question whether following the EBP model actually has any impact on client outcomes; and question what is the evidence that EBP is better at improving patient care than any other form of practice? (Butler, 2006; Clarke & Barkham, 2009; Dyer, 2008; Gryphonck, 2006). It is argued that a model which promotes practice based on evidence should have its' own evidence that following such a format results in improved quality of care (Chambless & Ollendick, 2001); which currently it does not (APA, 2006).

This chapter has outlined the definition of EBP; its aims; and some of the reported benefits and criticisms of this model; the following chapter will explore in more detail the most common method by which research evidence is embodied and used to guide and influence practice; clinical practice guidelines.

### **Chapter 1.3 Clinical Practice Guidelines**

Clinical guidelines are intended to review, synthesise and evaluate evidence (Pilling, 2008). Various organisations have been developed whose primary function is to achieve this purpose; these include the Cochrane Collaboration and the National Institute for Health and Clinical Excellence (NICE, 2007, 2009). Cape and Barkham (2002) place practice guidelines within an overarching umbrella of practice improvement methods, including outcome measurement and clinical audit; they view guidelines as being consistent with the EBP paradigm.

There have been mixed responses to clinical guidelines within psychological therapies, they have been greeted enthusiastically by some who applaud the recognition of psychological interventions within the health care service (Shaner, 2002), and with scepticism by others who perceive them as potentially restrictive (Hampton, 2002). It has been reported that research is infrequently utilised to inform practice (Baker, 2001; Marzillier, 2004; Morrow-Bradley & Elliot, 1986), a common response to the apparent lack or low uptake of EBP has been to assess practitioners' attitudes to EBP and clinical guidelines (Lucock, Hall and Noble, 2006; Pilling, Taylor and Price, 2006).

Prior to reviewing the research relating to practitioner attitudes, consideration will be given to some of the sources of contention which underpin the debates around guidelines. This divergence includes the methods used to create a guideline, and the type of research included within guidelines. A focus on research methods by necessity incorporates a consideration of the differing epistemological and theoretical conceptualisations which underpin them. The differences in research aims such as the demonstration of efficacy or effectiveness; and differing opinions regarding the therapeutic

approaches recommended within guidelines are further factors which divide practitioners and will also be considered below.

### *Guideline development*

The methods by which information used to generate practice guidelines and recommendations is gathered and analysed is intended to be transparent, reliable and reproducible, with the aim of minimising bias at all stages of the process (Egger, Smith & Altman, 2001). Appraising the available research frequently involves a systematic review; this is a clearly outlined method used to review all the relevant evidence around a particular issue. It follows a set protocol to enable replication (Hemingway & Brereton, 2009) and may include a quantitative synthesis and analysis of the results from a number of studies; a meta-analysis.

This process may be open to bias in various ways, from the methods used to select which research studies to include, to combining the results of studies that have used different outcome measures, or are based on different populations. The meta-analytic method has been questioned as its conclusions and resultant recommendations are based on an 'average' patient, this may be problematic and misleading as it may "fail to reveal the complex mixture of substantial benefits for some, little benefit for many, and harm for a few" (Kravitz, Duan, & Braslow, 2004, pp.661). The Medical Research Council has highlighted some of the problems in evaluating complex interventions using systematic reviews; including the potential for numerous and various outcomes, and in terms of the intervention used, adhering strictly to a particular protocol may not have been appropriate, making the evaluation more difficult (Craig, Dieppe, Macintyre, Michie, Nazareth, & Petticrew, 2008). The report emphasises that a key question when evaluating complex interventions relates to "whether the intervention works in everyday

practice” (Craig et al, 2008, pp. 7). This statement relates to the issue of the generalisability of research recommendations and questions relating to efficacy and clinical effectiveness.

### *Validity and Generalisability*

The issue of generalisability or external validity refers to the ability to apply findings from the research context to ‘real-world’ contexts of everyday practice. The process by which this generally occurs is by proximal similarity, meaning the confidence with which the findings can be applied increases when used with those who are most similar to those upon whom the research was based (Bower, 2003). Low proximal similarity has been cited as a factor explaining why there are often differences in the outcomes between the Randomised Controlled Trial (RCT) findings and those found in clinical settings as the populations may be quite different.

This type of research is concerned with measuring the efficacy of an intervention. Establishing efficacy relates to measuring the potency of an intervention when it is assessed under controlled conditions (Bower, 2003). The strict controls required within efficacy research makes it favoured within guideline development, the controlling of confounding variables increase the internal validity, thereby increasing the confidence with which change in the client can be attributed to the intervention (Bower & King, 2000).

This returns to the issue of validity; external validity refers to the degree to which the results of the study can be generalised over time, settings or other people, i.e. whether the people in the research trial are representative of those seen in other settings; and ecological validity, how well the aspects of the research trial compare to real world conditions and actual clinical populations (Shadish, Matt, Navarro & Phillips, 2000; Western & Morrison, 2001). The limitations



and criticisms of efficacy research and RCTs may influence receptivity to recommendations within guidelines that arise from this methodology. Further criticisms include: They are detached from clinical reality (Field & Lohe, 1992; Penston, 2003; Seligman and Levant, 1998), they ignore the process and content of therapy interventions (Ibanez, 1999; Murray & Chamberlain, 1999; Norcross, 2002), and they are seen as being simplistic and reductionist (Garfiels, 1996; Wilson, 1998).

Bamford (2009), speaking as a clinician involved in RCT trials, acknowledges that while some of these criticisms are valid, RCT trials have attempted to address some of these limitations. She proposes that rather than ignore the inherent variability that exists even within manualised treatment protocols, these factors should be explicitly measured (this point is consistent with recommendations within the Craig et al, 2008, report on evaluating complex interventions).

A solution to the difficulties inherent in efficacy research and RCT methodology is the drive for more research focused on establishing the effectiveness of (an) intervention(s). Effectiveness or clinical utility focuses on the potency of an intervention when carried out in routine clinical contexts, which may be impacted by heavy caseloads, waiting list pressures, practitioners at various levels of training, varying theoretical orientations and diverse client populations, to name a few (Barkham & Mellor-Clark, 2000; Long, 2008; Page & Stritzke, 2006). Consequently there has been a call for “evidence from routine practice – practice-based evidence, to be given greater weighting alongside efficacy and cost-benefit analysis in NICE guidelines” (Clarke & Barkham, 2009; pp.8). While there is a call for more research in ‘real-world’ settings upon which more ecologically valid claims could be made, there is also the connected

issue of what the target of change is and how this change is measured, which leads into the field of outcome measurement.

### *Measuring clinical improvement*

Evaluating one's own practice is arguably part of the routine procedure for clinical psychologists; there is a strong justification for doing so (see Sperlinger, 2002) and a variety of factors to consider: "The outcomes of psychological interventions are the amalgam of a complex of factors and...attempts to assess such outcomes need to take account of the complexity" (Berger, 1996, pp. 23.). This complexity means outcome measurement is not a unitary concept (Sperry, Brill, Howard & Grisson, 1996) partly due to the lack of consensus around what constitutes clinical improvement (Cape & Barkham, 2002). The decision about whether to follow EBP, in particular whether to follow a guideline recommendation, may relate to what the outcome of the recommended intervention is and whether this matches both client and therapist needs and goals (Hardy, Stiles, Barkham, & Startup, 1998; Thornicroft & Slade, 2000). Differences in opinion around clinical improvement may relate to wider issues regarding theoretical conceptualisations about mental illness/ distress (Jacobs, 2009).

### *Theoretical Conceptualisations*

Prior to research being conducted and incorporated into the 'evidence-base', decisions are made about what to research. This may seem an obvious point, but closer examination reveals the problematic nature of this first step in terms of conceptual structures and theoretical constructs (Sturdee, 2001). There are disparate perspectives on arguably all aspects of mental health, from those who conceive of all experience on a continuum of normality, to those who see clear distinctions between normality and abnormality, or health and illness (Bentall, 2003; Horowitz & Wakefield, 2007). Mollon

(2007) questions the NICE guidelines on the grounds of what he perceives as their lack of psychological content, in terms of providing a psychological framework or understanding of the target condition for which therapy is being recommended. There is concern that the medical model dominates within research, with participants in RCTs often being identified and grouped according to psychiatric diagnosis (Western & Morrison, 2001) and often restricted to a single diagnosis, which many argue does not represent the co-morbidity found in general practice. This view is supported by Meichenbaum (2003) who found that fewer than twenty per cent of those using mental health services have only one Axis 1 disorder (as defined within the Diagnostic and Statistical Manual version four, DSM-IV, APA, 1994). However, Pilling (2008) cites several authors who suggest co-morbidity in itself may not necessarily result in reduced outcome of the target intervention (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000). For those who question the validity of psychiatric diagnosis, EBP recommendations based on such a framework may not fit with their conceptual framework and recommendations may be less likely to be implemented as a result.

### *Psychiatric Diagnosis*

The issue of psychiatric diagnosis is a contentious issue in its own right and there are numerous sources to refer to these debates in more detail (e.g., Boyle, 2005; Pilgrim, 2007). The relevance of psychiatric diagnosis to the issue of EBP relates back to the ontological and epistemological assumptions which underlie psychiatric diagnosis. Epistemological positions reflect points of divergence between the conceptual frameworks used to guide practice and research and will be explored further below (Johnstone, 2000; Smail, 2005). Psychiatric classification systems have been accused of lacking conceptual and predictive validity; they are promoted as being "atheoretical and descriptive...as though this

means they are useful because they are neutral and scientific” (Pilgrim, 2000, pp.302). However, the very fact that with each issue of the Diagnostic and Statistical Manual (APA, 1994), diagnoses may be removed or added, highlights they are not neutral but situated in a particular cultural, societal and historical time. In claiming to be atheoretical and descriptive they are claiming a realist epistemological assumption that they are merely reflecting the world as it is. However, the view that mental difficulties are medical in nature has not always been nor is it still universally the case, rather they may be viewed as spiritual or religious issues not health concerns (Horwitz, 2002; cited in Hunsberger, 2007).

Psychiatric diagnoses are criticised on the grounds of saying very little about “aetiology, the frequency or intensity of ‘symptoms’, what interventions are most likely to work and the prognosis if left untreated...as such they are of little use to the clinician wanting to help a person” (Brown, 2002, pp239). Marzillier (2004) further questions what he perceives as the medicalised way of defining psychological experience and comments on the problems with psychiatric diagnosis such as the overlap between many ‘symptoms’ and the inability to reliably differentiate between conditions, which leads him to question how we can generalise from research that is based on poorly defined concepts (Holford, 2008). How one conceptualises the ‘problem’ at hand and how one chooses to intervene inevitably leads back to the issue of measuring outcome; if a successful outcome is considered to be the reduction of symptoms, this may not fit with other models who do not have this as a primary goal and where quality of life may be a more important issue (Persons & Silberschatz, 1998).

## *Epistemology, methodology and evidence*

### *Paradigm*

Researchers may operate from different paradigms (conceptual frameworks); their ontological and epistemological assumptions about the world can be very different. Philosophical assumptions about the nature of reality locate the overall perspective from which research is designed and carried out (Krauss, 2005). Ontology refers to *what* is 'out there' to know about, what it is possible for us to know (Krauss, 2005), while epistemology (deriving from the Greek word *epitêmê*, meaning knowledge) is the philosophy of knowledge or *how* we come to know reality (Trochim, 2000). Beliefs about how and what can be known will influence the types of research questions asked, accordingly the epistemological position influences the way research is approached which consequently influences the theoretical framework from which it is analysed (Flick, 1998). Historically the dominant epistemological position within clinical psychology has been one of positivism; which will be described in brief below.

### *Positivism*

A positivist epistemology views the world as an objective single external reality which exists in a fixed sense (Healy & Perry, 2000); it is not influenced by our *perception* of it (Kirk & Miller, 1986). This is referred to as the 'correspondence theory of truth' because it suggests that the world and all that it entails, directly determines our perception of it, as a result there is a direct correspondence between 'things' and their representation (Willig, 2001). Research approached from this position may view the purpose of research being to test hypotheses regarding relationships between variables, and to gradually reach theories which can have the status of being scientific laws or objective truth (Ashworth, 2008).

However, there are those who question the validity and usefulness of research within mental health which essentially takes a

hypothetico-deductive approach which may rely on linear-causal models (Barker, Pistrang & Elliot, 2002). Danziger (1990) asserts a similar view to this, suggesting that research related to psychological therapy, needs to be broadened beyond that of purely measurement and cause and effect relationships if the dynamic nature of therapy is to be explored.

The debates surrounding epistemological positions within clinical psychology have often been separated into a quantitative/qualitative divide; with quantitative methods being equated with positivism and qualitative methods with more constructionist approaches (although this distinction is somewhat artificial and there can be considerable overlap; refer to Harper, 2008; Kraus, 2005; & Miller, 1999, for further elaboration). Grypdonck (2006) expresses methodological concerns about the EBP movement, stating that qualitative methodologies are not given equal weight compared to quantitative methods within clinical practice guidelines (Goldenberg, 2006). McKenna et al (1999) go further and claim the current primacy of evidence derived from quantitative methods reinforces prejudices against certain forms and sources of evidence. However, this debate is not simply two-sided, rather there are a number of underlying attitudes reflecting preference for quantitative over qualitative methodology, and a search for exploratory over confirmatory research questions (Kimble, 1984). As indicated above methodological factors in the broadest sense in terms of quantitative and qualitative approaches underpin a large part of the discussions around EBP. Denzin (2009) states, "Qualitative researchers are caught in the middle of a global conversation concerning the evidence-based research movement...this conversation turns on the politics and ethics of evidence" (pp.139). Part of this 'political' debate relates to the historical dominance of the medical model and a positivistic perspective within mental health; Pilgrim and Treacher

(1992) and Parker (1992) provides a detailed overview of the history of 'psychopathology' and deconstruct the emergence of this dominance.

The debates around EBP can therefore be seen to extend to or from, the foundations of the philosophy of science. The position taken within this may influence the methodology chosen to frame, answer or explore the research question(s)/ area. The traditional positivistic philosophical position can be contrasted with post-positivism. From this perspective rather than there being one fixed reality, all observation is fallible, and we cannot 'know' reality with a certainty or truth that historically positivism claimed. From this viewpoint we all construct versions of the world based on our perceptions of it. Consequently we are all inherently biased by our cultural and historical experiences, and all our observations will be theory-laden and have the potential to change (Madill, Jordan, & Shirley, 2000). It is this tension between '*a truth*' and '*multiple truths*' that has led to the call, by some, for a paradigm shift within the definition of evidence and the types of research that are perceived to constitute 'best evidence' within the mental health field, that acknowledges the multiplicity of perspectives and broadens the type of evidence used to inform guideline development (O'Neil, 2002).

The philosophy of science and the range of positions within it are too vast to be explored in detail here; rather the aim is to illustrate how these frameworks feed into the EBP debate (this will be explored further in chapter 2.1). The final area to be considered within this section relating to clinical practice guidelines is the issue of particular therapeutic approaches being recommended.

### *Recommendations for particular therapeutic approaches*

There have been a number of criticisms of the increasing recommendation of CBT within NICE guidelines. One such criticism highlights the sheer quantity and variety of therapies that may come under the umbrella of CBT (Adams, 2008; Moloney and Kelly, 2004). Advocating an approach which in practice may take on a very different form from that carried out in the research trial may be open to criticism. The 'effective' agent or technique may not transfer to this other form (Gurnan, 2007); this line of argument would seem to be in agreement with a more clearly defined approach such as in manualised treatments. However, this then returns to the issue of what in the therapeutic encounter is the 'active' agent of change; is it more about the quality of the relationship as opposed to the particular technique or approach? (Messer & Wampold, 2006; Norcross, 2005). This issue is complicated further by those involved in RCTs openly admitting variability in therapy delivery even within research trials (Bamford, 2009).

However, Pilling (2008) in his discussion of the process of guideline development, asserts that while lack of evidence may not indicate a lack of effectiveness, it would not be appropriate to recommend interventions for which there is no evidence over those for which there is. This aspect again feeds back into questions relating to definitions of evidence and the evidence hierarchy; there may be evidence for other approaches but if the methods used are not considered to meet the 'quality' standards highlighted in the criteria used when constructing guidelines, they may be discounted.

EBP has been criticised for failing to take into account these factors and for its underlying assumption that patients and therapists are equal, definable, and constant (Seligman, 1995, referred to in Bamford, 2009). Dyer (2008) acknowledges that guidelines have the



potential to inform practice but states they may prove counterproductive to the process of therapy, he advocates continued debate within the profession and “input to the wider political arena on this issue” (pp. 19).

In summary, EBP refers to the process of basing practice on research findings and recommendations; this is considered to reduce variability in practice with the aim of improving patient care. However, the research evidence upon which EBP recommendations are based stems predominantly from a particular epistemological position; essentially positivistic in origin. Researchers who hold a different epistemological position argue their research is marginalised and the primacy of the dominant, broadly positivist paradigm reflects and serves wider aims and objectives (Akobeng, 2005; Evans, 2003). These include governance frameworks (guidelines and standardised practice provide a measure against which actions can be judged); the monitoring of practice in line with the EB aims to reduce the reliance on clinical judgement, something that is hard to define, control and quantify. The link between clinical practice and research is directly addressed within the field of clinical psychology by the promotion of the scientist-practitioner model which will be explored below.

#### **Chapter 1.4 The Scientist-Practitioner model (SPM)**

The scientist-practitioner model explicitly connects and emphasises the aspects considered to define the role; that clinical psychologists should function as both scientists and practitioners who can conduct research as well as clinical work. The clinical psychologist is envisaged to maintain a research focus in their clinical practice (basing their work on research evidence) and practice relevance in their research (i.e. conducting research that has clinical utility); this is considered to represent a commitment to bridging the gap between scientific foundations and clinical practice (Belar & Perry, 1992).

Whether the SPM accurately reflects the role of the clinical psychologist has been a continual source of debate since the inception of the term; Morton, Patel and Parker (2008) highlight how such a debate is still relevant to contemporary practice (Warner, 2006).

As is the case with the phrase EBP, the term 'scientist-practitioner' is subject to interpretation and Milne, Britton and Wilkinson (1990) propose a single conceptual understanding of what it means to operate as a scientist-practitioner is unlikely. Kennedy and Llewelyn (2001) provide an overview of the key developments within psychology which have impacted on the role of the clinical psychologist; they highlight how the term scientist-practitioner has varied throughout history, changing in meaning depending on context. Bauer's (2007) perspective is grounded in practice in the US, which arguably has different contextual factors than the UK (see Pilgrim & Treacher, 1992, for a further overview of the historical developments of the clinical psychology profession in both America and the United Kingdom). He states that "clinical psychologists trained in the scientist-practitioner tradition are almost exclusively focused on quantitative research methods, with an attendant emphasis on measurement precision, quantitative statistical analysis, and tightly controlled experimental design...In contrast, qualitative approaches...seek to evaluate the quality, or essence of human experience using a fundamentally different methodological and analytic framework" (Mays & Pope; 2000) (pp. 689). The equation of the SPM with quantitative methods has been cited as contributing to a negative perception by students of this model (Aspensen & Gersh, 1993).

As there has been a drive for EBP in healthcare, there has been a focus on whether such a model is consistent with the practice of the

clinical psychologist and its guiding framework the SPM. Bauer (2007) asserts that in order to promote EBP within psychology the process by which evidence is incorporated into practice is worthy of study. An example includes, what evidence is good enough to influence a clinical decision? He concludes that if clinical psychologists are to assimilate the EBP way of thinking, this will necessitate the incorporation of the content, concepts and techniques of EBP at all levels of research and clinical training. There are several questions relating to this assertion; what is the drive behind the need for this assimilation and more importantly, does it differ from current practice? Kennedy and Llewelyn (2001) for example, collapse the two terms EBP and SPM and refer to an evidence-based-scientist-practitioner; their perspective does not see the two as separate hence there would be no need to assimilate that which is already an established part of the role. This further highlights the variability in how these terms are defined and employed.

The SPM model has been questioned on several grounds, including the feasibility of combining research and practice into the same training model. It has been suggested there may be inherent differences between those who are attracted to research and those whose interest relates to practice, and attempts to combine these spheres may be inappropriate (Holland, 1986; Frank, 1984). However, Morton, Patel and Parker (2008), suggest that most psychologists aspire to be scientist practitioners but that clinical demands militate against research activity. Their research employed a questionnaire administered to their psychology department, which inquired among others, about attitudes towards research and how important they regarded it to be. There was generally a favourable attitude towards research and it was felt to be very important to the profession, although only around half of them were research active. The reasons stated for this were a preference for clinical work, lack of

time, lack of resources, limited opportunity and other demands or priorities. Morton et al (2008) emphasise the importance of clinical psychologists being research active as one way for the profession to justify its value, and for why they cannot be replaced by a Psychology Associate or Advanced Practitioner CBT Therapist. In this sense advocating the production of research becomes tied to the need for professional survival; it becomes a means of maintaining, promoting and protecting the profession (Pilgrim & Treacher, 1992).

Morton et al (2008) stress the importance and relevance of the scientist-practitioner debate within contemporary practice, in light of changes in mental health services, including clinical and research governance outlining the expectations and responsibilities of clinicians. They state that "clinical practice is no longer autonomous and should be informed by the evidence base" (pp.35). This comment connects back to the question of what constitutes the evidence base and what guides decision making when the 'evidence-base' is limited? Emerson, Hatton, Bromley and Caine (1998) state that "attending to the 'evidence-base'...should underlie clinical practice...however; the scientific 'evidence-base' may be found wanting in specific situations...in such situations the importance of adopting a 'scientist-practitioner' approach becomes paramount" (pp.9-10). This would seem to suggest the scientist-practitioner approach follows after an EBP approach. Emerson et al (1998) describe the SPM as having five key stages: 1) formulation of the problem, reflecting current scientific knowledge about the underlying psychological processes that may underlie or be suggested by the presenting problem, 2) the hypothesis derived from the formulation should be empirically tested, 3) the model used to account for the problem should be revised as further information is obtained, 4) the intervention selected should be based on the model upon which the formulation was constructed; and on scientific evidence relating to the effectiveness of the potential

interventions which may produce the desired outcome, 5) the outcomes of the intervention should be evaluated using a scientifically valid approach. Emerson et al (1998) stress the importance of 'meaningful outcomes' which is broader than simply measuring changes in the frequency of a target problem, for example. The aforementioned model harks back to Shapiro's (1967) original conceptualisation of the SPM; he envisaged clinical psychology to be an 'applied science'. The applied scientist in this regard applies "scientific principles of observation, hypothesis generation and testing to the individual patient" (Shapiro, 2002). Emerson et al (1998) acknowledge the evidence-base will always be incomplete and in such situations of uncertainty they suggest the skills of the scientist-practitioner come to the fore. In this sense the SPM is not restricted to carrying out research per se, but is about an approach to practice.

In summary, one of the guiding frameworks for clinical psychology is that of the SPM, this promotes the view that clinical psychologists should be adept at research and practice. There has been much debate around whether this accurately reflects the role, with the majority of clinical psychologists not actively conducting research. It has been suggested that clinical psychology training needs to incorporate an EBP philosophy and hence an attendant emphasis on clinical guideline adherence; previous chapters have provided an overview of some of the debates that may make such a move problematic. Corrie and Callanan (2000) emphasise the importance (when debating or critiquing the model) of recognising the political, social and economic context in which it arose; such an acknowledgement leads to exploring current contextual changes in the United Kingdom and the potential impact they may have on the notion of the SPM; the following chapter addresses this.

## **Chapter 1.5 Recent contextual factors in the United Kingdom**

There have been a number of recent developments within the clinical psychology profession and in the wider health system as a whole, which have brought the issue of EBP to the fore. A brief outline of some of these will be covered to provide a current context for clinical psychology practice.

*From evidence to guidelines to service development:*

*Improving Access to Psychological Therapies (IAPT)*

IAPT is a government drive to increase access to psychological therapies (initially) for anxiety and depression for those of working age. It arose from a London School of Economics (LSE) report advising that psychological therapy should be available to everyone in Britain (LSE, 2006). The economist Lord Layard supported this drive by emphasising the 'reduced expenditure on incapacity benefits from people being able to go back to work' (LSE, 2006; Layard, Clark, Knapp & Mayraz, 2007). The IAPT programme constitutes the largest UK investment in psychological therapies provision to date with £173 million being made available to increase access to psychological therapies (Barkham & Parry, 2008). The programme supports a stepped-care approach with low-intensity interventions such as computerised CBT (cCBT) for mild anxiety and depression, moving into more 'high-intensity' individual CBT for moderate anxiety and depression.

The development of IAPT has been met with a mixed response within the field of mental health, with many positive responses regarding such an injection of finance into psychological therapies (Turpin, 2007). However there has been some scepticism and concern (refer to Clinical Psychology Forum 181, 2008, for some of these discussions), regarding the; "simplistic 'illness' model and an overly optimistic assessment of how effective psychological treatments may be" (Marzillier & Hall, 2009, pp.396). It is argued

that the medical model assumption that depression is a discrete condition that will get better given the right treatment, fails to take into account wider societal and systemic factors which may influence depression and anxiety (social and economic factors such as poverty), the question is posed, “are people really ill or are they responding to the realities of stressful and difficult lives?” (Marzillier & Hall, 2009, pp.397). It is here that again the debates return to the question of psychiatric diagnosis, with the increasing proliferation of diagnoses seen as “reifying ordinary experiences as illnesses, and pushing people into having formal treatments” (Bentall, 2003; Horowitz, & Wakefield, 2007). Howells (2008) refers to the IAPT model as ‘the medicalisation of misery’; this perceived alignment in psychological services with the medical model has received much attention (Boyle, 2006).

The relevance of this particular development for this research is that while guidelines are seen as the embodiment of EBP (Dyer, 2008), IAPT can be considered the next step and represents the embodiment of guideline recommendations. Rachman and Wilson (2008) state that: “Implicit in the planning of the expansion (of IAPT) is an acceptance of the need to insist on evidence-based treatments. This necessary insistence is a relatively recent development in clinical psychology...another matter that arises from the expansion is the acceptance that evidence from randomized controlled trials is transferable to routine practice (and that)...the standard rejection of evidence from controlled trials is no longer tenable” (pp.294). While Rachman and Wilson (2008) support such a move, unsurprisingly this evokes a number of the debates outlined above regarding EBP and all that this encompasses in relation to the practice of clinical psychology (refer to *The Psychologist*, 2009, 22(5) for further debates regarding the implication for clinical psychology).

Nel (2009) expresses concern that clinical psychology has adopted the medical model and asserts that from a psychological perspective, formulation would guide the most appropriate intervention rather than it being predetermined based on a person's diagnosis (Marzillier & Hall, 2009). Nel (2009) expresses concern over the recommendation of CBT, and cites research which highlights therapist quality and the therapeutic alliance as being the effective components of therapy as opposed to the particular model (Norcross, 2002; Wampold & Brown, 2005). Mollon (2008) reiterates this point by returning to the issue of therapist variance as a factor in therapeutic outcomes as opposed to variance between therapies.

Nel (2009) endorses similar sentiments to those by Gilbert (2009) and Casement (2009), that the profession of talking therapies would do well to "accept and work with the complexity of underlying inclusive possibilities of our different models and theories, rather than to opt for the artificial and temporary certainty that any one model (however good it is) can offer us" (pp.8). A related issue is that of effectiveness and how the assumptions underlying the IAPT programme and expectations regarding CBT and therapy in general may be misguided. Layard (2007) in employing a medical term speaks of people being 'cured', and further descriptions of the tasks of IAPT refer to "doses" of therapy (Turpin, Richards, Hope & Duffy, 2008, pp. 5). This analogy with illness has been questioned, with an assertion that the perceived outcome of therapy is considered simplistically and fails to consider the myriad of factors affecting outcome (Dowrick, 2004; Marzillier & Hall, 2009). Roy-Chowdhury (2010) speaking as a service lead and chair of his local IAPT project group, (and who describes himself as being 'broadly sympathetic to its aims',) cites a number of issues that need consideration. These include an emphasis on the "technical rather than the interpersonal aspects of therapy" (pp.26), the importance of therapist expertise and experience; and the importance of "cultural location and social



context” (pp.27). While not an exclusive problem for IAPT, Roy-Chowdhury (2010) highlights the difficulty with therapy in that; “The Euro-American consumerist construction of the decontextualised individual provides us with a narrow lens with which to view psychological problems, their causes and treatments. IAPT should embrace the search for a conceptual base for psychotherapy that takes as its focus the individual and the social and cultural contexts within which she lives her life” (pp.28).

Further comment on the IAPT programme relates to questioning the choice of who should benefit from increased access to psychological therapy. The choice of targeting adults with relatively mild forms of anxiety and depression with the aim of them returning to work has been treated with close to disdain. This being on the grounds that other populations who may not feed into the economy such as children, older adults and those with learning disabilities have been left out of this equation, and the allocation of resources. However this has been acknowledged in more recent guidance with the explicit recommendation that IAPT services need to determine how they can meet the needs of both younger and older age clients (DoH, 2010).

The IAPT programme with its attendant focus on individual interventions is questioned by those who advocate a more community psychology perspective (John & Vetere, 2008; Orford, 2008). Waldergrave (2003) considers the social, economic and political contexts that may be implicated in the onset of many clinically identified problems, and advocates a socio-economic solution, as opposed to locating the problem in the individual and their ‘dysfunctional assumptions’. This is a view held by Howells (2008) and an ethos shared by Nel (2009) who suggests the clinical psychology profession should reflect upon its’ position within this

(health care) system and what it proffers to do and achieve in its interventions. Indeed, the impact of service developments such as IAPT, have led to the Division of Clinical Psychology examining the ways in which the profession may be effected by such changes (Mental Health Strategies, 2007). The identified need for such a report emphasises an earlier point, that rather than being neutral, EBP and clinical guidelines can impact on group and individual identity; the potential threat to one's profession may impact on receptivity to- and implementation of- such guidelines (Mollon, 2007; Rake, 2008; Smith, 2007).

### *Clinical Psychology Training*

As highlighted above, the Division of Clinical psychology commissioned a report to gain an understanding of the requirements of psychologists by those commissioning services (Mental Health Strategies, 2007). This aimed to identify changes that need to be made and to devise a marketing strategy for the profession of Clinical Psychology. Some of the findings and recommendations include ensuring trainees are sufficiently trained to deliver NICE recommended interventions such as CBT. The report recognised there were a number of gaps in meeting NICE guidelines; but also raised the issue of the perceived value of (British Association for Behavioural and Cognitive Psychotherapies (BABCP) accreditation, and the benefits of aligning training with the NICE guidelines. The report highlighted as a perceived threat to the profession, the focus upon CBT to the detriment of other approaches, the predominance of the medical model, and the perceived increasing medicalisation of services, and moves towards symptom focused models, such as NICE recommendations and the use of ICD 10 codes for clinical coding. Clinical psychology training courses have modified their training programmes in light of these recent developments, and increased the

focus on CBT; consequently the aforementioned debates are encapsulated within this development.

In summary, the IAPT programme has stimulated discussion around psychological service delivery models, the motivating factors behind service development, the types of therapy offered, how psychological distress is described, categorised and responded to, the potential breadth of psychological knowledge and research (and whether this is being unduly curtailed) and how the clinical psychology profession is responding to these aspects. As stated previously the guiding model for clinical psychologists is widely promoted to be that of the scientist-practitioner. Broadly speaking this envisages the role to entail producing and consuming research, which is fed back into the professional and scientific communities (Hayes, Barlow & Nelson-Gray, 1999). As a model this appears to fit with the notion of applying evidence from research to practice. However, the application of research to practice which, at first sight, seems to be promoted as a straightforward process, is fraught with difficulties and debates from a conceptual to a practical level. Research has attempted to explore these aspects with practicing clinicians.

## **Chapter 1.6 Practitioner attitudes and influences on practice**

While there are various official definitions of EBP such as that adopted by the APA (2006), research has indicated a lack of conceptual consensus with practitioners holding various beliefs regarding this concept; with similar variability in relation to its perceived relevance to clinical practice (Arrons, 2004). Research into practitioner attitudes towards EBP appears to have several aims; developing an increased awareness of factors that may inhibit or facilitate the uptake of EBP (with a view to making adaptations to increase compliance); and within psychological therapy specifically,

exploring attitudes to the SPM and whether this is consistent with an EBP model. This may lead to an examination or questioning of the reasons why the EBP 'movement' has arisen, how each profession is responding to this, and for some, questioning it; some of the research pertaining to this area is summarised below.

Practitioner attitudes towards EBP were explored in a study by Nelson, Steele and Mize (2006), their stated rationale for the research is: "It is unclear whether the objections to the EBP movement reflect the views of most clinicians or just a vocal minority. As the field moves toward EBP, the attitudes of practitioners...will play an important role in implementation efforts...understanding practitioner attitudes...will be crucial to the successful movement of EBPs into clinical settings" (pp.399). Focus group methodology was employed in order to garner the complexity of practitioners' attitudes. Participants were employed across two child and adolescent community mental health centres based in a Midwestern state in America; they included 12 social workers, four Ph.D. -level clinical psychologists, two masters' level psychologists and one advanced nurse practitioner.

A focus group was held at each of the centres, members were asked to respond to seven prepared questions (such as 'What are the challenges of implementing evidence- based practice? Where do you get your information on treatments?' How helpful is treatment research in your clinical work?'), the sessions were transcribed and coded for themes. The researchers do not provide a particular theoretical framework from which the development of these themes arose, bar that recommended by Krueger (2000). Participants expressed the desire for more research in clinical settings, for more flexibility in tailoring treatments to the individual client, for more focus in research on the therapeutic relationship, and for research to

be explicit in how it can be translated into clinical practice, (taking into account the complexity of 'every-day' client presentations). Barriers to implementation included; time-restraints preventing the learning of new protocols and funding (this is an added variable in America with third-party payers financing treatment, and if these agencies will not fund the treatment it cannot be delivered). Factors perceived as increasing implementation of EBP included; having flexibility within the intervention to be able to be responsive to client needs as and when they arise, rather than sticking rigidly to a programme; and an emphasis or acknowledgement of the therapeutic relationship as a change mechanism.

Having such a multi-discipline group may have the advantage of obtaining a broad perspective over the service, but it is likely that different professions may have slightly different perspectives towards EBP and may be subject to varying guidelines dependent on their profession; as such, exploring the attitudes and experiences of a single professional field has merit. Participants were from two community mental health centres; however, it is also unclear whether both operate using the same policies and organisational ethos; this may impact on participant views and practice.

Themes within the analysis are described as 'ideas that were expressed repeatedly (at least three times), and appeared to reflect the general consensus of the group.' The choice of three times appears to be arbitrary and the authors do not provide a rationale; they proceed to explain they have not provided actual frequency counts as such counts can be misleading regarding strength and importance of a theme (this seems to contradict their earlier choice). In only selecting those themes that represented a convergence of opinion; they may discount the exceptions and divergence of opinion which may further illuminate the topic, and instead opinion may be

subject to a form of group think. The researchers acknowledge that each group held different views overall in relation to EBP. One generally viewed it as positive and the other generally negatively, this may relate among others, to the influence of more dominant members within each group, and as the authors note it may relate to differences in ethos within each centre.

The researchers did not provide a definition of EBP which has both advantages, in allowing a wide scope of interpretations, but disadvantages in that participant conceptions were not elicited, therefore there may be variance in how the term is understood and the frame of reference upon which opinion was based. It also appears that for many, EBP was equated with manualised interventions which are highly structured session by session programmes; this may reflect the context within the United States and the emphasis on empirically supported treatments (ESTs). ESTs are 'treatments for specific disorders' that have been found to be efficacious in RCTs (Chambless, Baker, Baucom, Beutler, Calhoun et al. 1998). The researchers suggest exploring attitudes towards EBP within different professions as a future area for investigation, along with the need to explore individual practitioners' definitions and understanding of EBP.

The conceptual confusion highlighted in the above study between EBP and ESTs was further explored with psychology graduates in the United States. Luebbe, Radcliffe, Callands, Green and Thorn (2007) outline the increasing move towards the empirical evaluation of the efficacy of therapy (Kendall, 1998) and the rise of ESTs within the US (Chambless & Hollon, 1998). This has resulted in a greater emphasis in teaching ESTs in APA accredited psychology doctoral programmes. The researchers note the confusion within professions between ESTs and EBP (Hays et al, 2002). EBP is often equated to ESTs as opposed to the definition outlined by Sackett et al

(1996); Whereas EST are the specific interventions or treatments, EBP is a process, "which incorporates the retrieval and examination of the scientific evidence" (pp.645) and includes client preference and clinical expertise.

The researchers emphasise the importance of finding out how the next generation of practitioners perceive the EBP initiative; primarily as they feel it may be necessary for training to adapt in response to "shifts in the professional world of health" (pp. 644); and in order to facilitate the integration of research and practice. Their research was conducted to gain an insight into the level of awareness of EBP of current clinical psychology graduate students. Participants were enrolled on graduate programmes in clinical psychology that adhere to a scientist-practitioner training model. Participants completed an online survey questionnaire specifically created for the research, 1,195 responses were used in the analysis. Participants were asked to provide a narrative definition of the term EBP in psychology; they were then presented with the APA definition, followed by 18 questions, with responses indicated on a likert scale ranging from 'not at all' to 'to a great extent'. Question areas included assessing their experience with and exposure to EBP in both class and practice settings, attitudes about EBP and how it may influence their future clinical practice and research, how they at present stay abreast of current research, and factors that influence their treatment planning.

Only 3.7% of responses to the definition of EBP included all three elements of the APA definition (the use of the best research, clinical expertise and client factors). Almost all of the responses (97.4%) included reference to using research, and 81.1% of the definitions only included research. With regard to how they planned treatment, the highest rated influential factor was supervision,

followed by patient-specific factors; these were rated as used more than research evidence. Differences were found between those who envisaged their future careers to be mainly research based (they rated research in the form of RCTs and systematic reviews as highly influential) compared to those who foresaw a mainly clinical practice role. Those whose intention was to focus on clinical practice expressed less agreement with the principals of EBP; the researchers claim they find this ironic in that this role will still require the evaluation and integration of research with therapist expertise and client preferences. However, as the respondents were restricted in their responses and further elaboration as to their reasoning was not possible; to draw any assumptions about which aspect was in disagreement is limited. The researchers equate research with empirical evidence and do not seem to acknowledge that holding an alternative epistemological position may well be a factor in evaluating evidence and its applicability to one's own practice; they merely seem to suggest that an increase in training on EBP and ESTs will result in an increase in receptivity and uptake of such research.

As regards further limitations, providing a definition of EBP may have compromised the validity of the response to a later question which asked if the students agreed with the principles of EBP. It could be argued that having been presented with a definition provided by the governing body of their profession, may have resulted in a response bias as over 70% endorsed the I agree 'quite a bit' with EBP response. Generalisability is problematic as trainee clinical psychologists from other countries are subject to differences in training and wider contextual factors. However this research does highlight areas which may be pertinent issues to explore with trainees in their own training contexts. While the above study appeared to neglect the impact epistemology may have on attitudes towards EBP (perhaps reflecting an implicit assumption and equation with a



positivistic empirical view of science and research?)); a further study aimed to identify correlates of self-reported EBP use in practice (and while not explicitly referring to epistemology they considered theoretical orientation as a potential variable relating to EBP use).

Nelson and Steele (2007) conducted an online survey of 214 mental health professionals across 15 states in the USA (including Ph.D. psychologists, Psy.D. psychologists, master's level psychologists, master's level clinical social workers and those who selected 'other') who had a range of theoretical orientations (psychodynamic, cognitive-behavioural, humanistic and others). Participants were asked 'How often do you use 'evidence-based practices' in your clinical work?' this was indicated on a four point likert scale ranging from 1 = never/almost never, to 4 = always/almost always. Participants were also asked whether they had ever taken a class in evidence-based treatments, were asked to rate the openness of their primary clinical setting to EBPs, and were given two four-item scales; one to assess positive attitudes toward treatment research, and one to assess negative attitudes towards treatment research.

The main results indicated significant differences between theoretical orientation with behavioural or cognitive-behavioural reporting greater EBP use compared to other approaches. Attitudes toward treatment research were significant predictors of self-reported EBP use, as was the participation in an EBP class; with positive attitudes and attending a class resulting in reportedly greater use of EBP. The receptivity to EBP by the practitioners' institution also affected attitudes towards, and use of, EBP. The researchers acknowledge that decisions about whether to implement EBP are not made in a vacuum and social influences (such as institutional culture) can affect practitioner decisions. That those of a CBT orientation were

more likely to report positive attitudes towards, and utilisation of, EBP was considered to reflect the fact that most EBP treatments adopt a CBT orientation. They highlight the need for more effectiveness research in clinical settings, suggesting this may improve attitudes towards, and increase and use of, EBP.

Criticisms of this research include that EBP use was assessed using a single question (How often do you use evidence-based practices in your clinical work?). The concept of EBP is arguably broad and the design of the question (while measuring frequency) does not account for the variance in how the concept may be interpreted. The researchers note that those from a behavioural or CBT orientation indicated a greater use of EBP; this may relate to a general equation of EBP with EST and manualised treatments (as previous research has indicated). It may be that those from other orientations use research of a different form (single case studies and those not based on RCT trials), which could be considered evidence albeit in a different form. A greater exploration of these concepts could have illuminated this area, particularly in light of the complexity of the EBP model. While the majority of research has been carried out in the United States there are related studies in the UK as indicated below.

Lucock, Hall and Noble (2006) acknowledge the application of evidence to practice is a complex issue, as is its relationship to expertise and judgement (as defined in the Sackett, 1996, definition given above). They suggest that exploring the various influences on clinical practice may inform the extent to which EBP has an effect on practice. If other factors such as patient characteristics, supervision and case formulation are important, they suggest these too should be evaluated and evidence based, they assert that acknowledgement of these factors may make EBP more acceptable and effective. To explore these issues a questionnaire design was used, participants

were 95 qualified psychological therapists from various therapeutic orientations (employed in various NHS psychological therapy or psychotherapy services; professional backgrounds included clinical psychology, counselling, nursing, psychotherapy, medicine, occupational therapy and others not specified) and 69 clinical psychologists in training within one of three courses in the UK.

The questionnaire included 39 items over four categories including training, literature, practice and personal factors; items were rated on a six point scale from 0, 'not at all', to 6 'a great deal', (the researchers do not provide further detail in relation to specific questions). The qualified group rated the following as being most influential on their practice; current supervision, client characteristics, client feedback, psychological formulation, intuition/judgement, professional training and post qualification training. The trainees rated current supervision, past supervision, client characteristics, client feedback, psychological formulation and professional training as the highest influences. There were significant differences between the qualified and trainees for 13 of the factors, with trainees rating textbooks, electronic sources (such as journals), supervision, client characteristics and formulation more highly. Qualified therapists rated major life events, personal therapy, supervision, conferences and providing teaching as more influential. There was not a significant difference between the two groups in their rating of treatment manuals and evidence based guidelines. Therapeutic orientation was relevant, with CBT therapists rating electronic journals, treatment manuals, government documents and evidence-based practice guidelines higher than the other therapists.

Overall the results indicated that professional training, clinical supervision, client characteristics, client feedback and psychological formulation were the most influential factors for both qualified

psychotherapists and trainee clinical psychologists. The findings also suggest that CBT therapists use EBP to a greater extent than other therapists. Intuition and judgement were rated higher than EBP items; the researchers suggest these aspects warrant further investigation in terms of their influence on client outcome. The researchers expressed surprise that EBP was not rated higher by the trainee clinical psychologists considering the tradition of research and EBP in training. However, they assume that EBP will be incorporated within supervision and professional training which were rated as highly influential in their practice.

In interpreting their findings the researchers make reference to similar reported barriers to implementation outlined above (such as clinicians concern over the applicability and clinical utility of research findings to routine practice, the basing of many manualised treatments on a disorder model, and finding manuals restrictive). That clinical judgement and client factors were rated as highly influential was seen as supporting the view that effective practice is best seen as an amalgamation of flexibly using EBP guidelines combined with client and therapist factors. The researchers suggest the findings illuminate factors that influence psychological practice, and the relatively low use of research and evidence. Considering prior research has highlighted that clinical setting and professional background impacts on receptivity towards EBP, this may have been a useful factor to explore. The choice of questionnaire methodology meant participants' responses were restricted; qualitative exploration with practitioners may have provided useful feedback on why respondents chose to use particular sources of information and/or guidance over others. Of note in this research is the higher rating by trainee clinical psychologists for textbooks and journals, would this indicate that they are operating as scientist-practitioners in the sense that they are evaluating and implementing the findings from research

into their practice? Could it not be argued that their practice is still influenced by the evidence even if it is not in guideline or a manualised protocol? Answers to this, (as indicated previously), depend on how the concepts of evidence are defined; Corrie and Callanan (2001) attempted to explore this further.

The SPM and EBP are guiding models, to some extent, within clinical psychology practice and discourse. Corrie and Callanan (2001) suggest there is a need to re-examine the SPM to explore whether it competes with, or complements, EBP. In the current climate which increasingly emphasises the need for practice to be grounded in research evidence, to be evidence-based, it is necessary to understand factors that influence attitude towards research.

Corrie and Callanan (2001) conducted interviews with eight therapists, comprising a mix of counselling psychologists, clinical psychologists and trainee clinical psychologists. These were employed across NHS and private settings in the UK; worked from differing theoretical orientations and across a range of client groups. The interview included asking participants about their reasons for undertaking their primary training, their perceptions of research and the extent to which they felt it influenced their practice, their understanding of EBP, and its value for influencing practice. Participants were asked to provide their own definitions of the term scientist-practitioner and whether this model was consistent with their training and current practice. Finally they were asked how they believed their practice had developed over time in terms of acquiring skills and the use of research findings.

Grounded theory analysis 'uncovered' beliefs about the role of research which were broken down into eight categories including; the perception that it is a professional responsibility, a contributor to

effective practice, and also a political tool. There were some differences between professional groups, with counsellors perceiving research as somewhat inaccessible. Research was referred to exclusively in terms of statistical analysis by all participants, and there was a belief that the translation of research findings to clinical practice could not be achieved directly. Several participants felt there was a lack of conceptual clarity about the term. In terms of the SPM, some participants believed that adhering to the model imposed certain standards, ways of practicing, and embodied a professional identity. For others the traditional definition of the SPM was restricting; however, each participant had their own individual definitions which indicated the variability in how the concept is interpreted. For some this disparity was a positive thing in that it allowed therapists to adapt it to suit their own philosophical position, for other therapists the diversity seemed to be perceived as a threat to the future of the therapists' roles. Corrie and Callanan (2001) comment on the variety of interpretations of the SPM and suggest that debates around the model need to be qualified with regard to which philosophical position (in terms of definitions of science) they are drawn from; they recognise the SPM will look very different depending on the epistemological lens it is viewed through. They conclude that the SPM "transcends the inevitable constraints of basing therapeutic practices exclusively on empirically driven evidence" (pp.136). They suggest it complements EBP and provides a framework through which knowledge can be gained "through reflective, yet systematic debate and analysis" (pp.136). They suggest further exploration of the varying ways in which the SPM is interpreted is important, as it may reflect attitudes towards research and EBP.

## **Chapter 1.7 Summary and research Aims**

In summary, EBP and the SPM are presented, by proponents of the models, as relatively straight forward concepts that should/could be easily incorporated into professional practice; a closer examination reveals the complex and multifactorial aspects underlying them. The recent IAPT service development programme (CSIP, 2007) has revitalised some of the debates around research and evidence and highlights the many differing perspectives which exist within the field of clinical psychology.

Research has attempted to delineate these various positions and consider how they may impact on professional decision making and practice. Such research indicates professionals may not access or base their decision making on research evidence (particularly when this takes the form of practice guideline recommendations).

Exploring with clinical psychology trainees their perception or understanding of EBP is important for a number of reasons. As a profession, clinical psychologists are encouraged to be scientist-practitioners, part of this can be considered to involve contributing to the evidence-base through conducting research. However, research output from qualified clinical psychologists is reportedly low (Baxendale, 2006; Cooper & Turpin, 2007; Morton, Patel & Parker, 2008). Individual philosophies about science, research and evidence may be one factor influencing this (Corrie & Callanan, 2001), as well as opportunity. There have also been a number of calls for the SPM to be revised with many clinicians claiming it no longer captures the work of a clinical psychologist. EBP is promoted as being 'The' way of practising, but if this term does not denote 'A' singular understanding of what is meant by this phrase, then what are the implications for the utility of the term? And if the term refers to one view of 'evidence' then what are the implications of this? The current changes within mental health service delivery, present an opportune moment

to revisit these models and explore how the next generation of clinicians conceive them, whether they represent current practice and whether they are still considered to have utility.

In exploring these aspects with current trainee clinical psychologists there is a desire similar to that expressed by research conducted by Corrie and Callanan (2001) to: “contribute to a fuller understanding of factors that impinge on therapists decision-making in services where evidence-based practice is emphasised as the primary ideological framework” (pp.137). I have approached this from a social constructionist perspective and I am interested in current UK clinical psychology trainees construct these models and their attitudes towards these concepts.

This research aims to expand on existing research by exploring EBP and the SPM with clinical psychology trainees and address some of the identified gaps such as:

- Exploring the issue of EBP with a single profession (including participants from a number of professional backgrounds was considered a limitation in previous research), (Nelson, Steele & Mize, 2006);
- To investigate how UK trainee psychologists perceive and construct EBP, how receptive they are to it and how it fits with their practice (Luebbe et al, 2007);
- To investigate the SPM both in relation to the EBP model and, as a framework; how it fits with trainees practice.
- To explore how recent changes in the context of the delivery of psychological services (i.e. the IAPT programme), has influenced trainees perception of EBP and the SPM. This development has initiated much debate within the profession.



## **Chapter 2: Extended Methodology**

### **Chapter 2.1 Design**

A qualitative methodology was adopted; three focus groups were conducted with trainee clinical psychologists from three separate doctorate clinical psychology courses; transcripts were analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis is a flexible method that can be approached from a number of theoretical or epistemological positions. The analysis procedure and the method itself are described in more detail below.

### **2.2 Theoretical Underpinnings**

Prior to describing the theoretical position of the present research, a brief consideration of qualitative approaches and the centrality of epistemology within this, will be presented.

#### *Qualitative Research*

Qualitative research, a heterogeneous field, tends to be framed within 'what', 'how' and 'why' questions, as opposed to 'how much' or 'how many' questions (Draper, 2004); and is more exploratory than confirmatory (Rennie, Watson & Monteiro, 2002). Language is the focus of this research; it may be gathered via interviews or focus groups, transcription of therapy sessions, a printed document such as a newspaper article or policy document. It may have the aim of understanding and exploring a person's feelings, thoughts, experiences, ways of seeing or understanding the world or ways of communicating (Barker, Pistrang & Elliot, 2002). This broad, diverse field incorporates a number of theoretical perspectives and related methods of analysis, underpinned by various philosophies of science (Madill, Jordan & Shirley, 2000; Willig, 2001).

### *Epistemological positions*

Qualitative research has been separated into two main traditions by some, phenomenology (the study of people's experiences and ways of seeing the world) and constructionism (concerned with how language is used to structure and manage the world), (Barker, Pistrang & Elliot, 2002); or is seen as lying on a continuum between realism and relativism by others (described below), (Willig, 2001). Barker, Pistrang and Elliot (2002) refer to Hamlyns' (1970) description of epistemology, of which he asserts there are four fundamental epistemological positions or criteria of truth. Firstly the correspondence theory of truth (outlined below), coherence theory; stemming from a rationalist perspective a belief is held to be true if it is internally consistent. A pragmatist position, which asserts a belief is true if it is useful, and a consensus position which is considered true if it is widely held and shared by a group of people. As Barker, Pistrang and Elliot (2002) highlight, all of these positions have both merit and flaws and none is adequate on its' own. Historically, psychological research has been grounded in a positivist framework.

### *Positivism*

A strict positivist epistemology is less common in current psychological research, and the term can be used to refer to positions that would not actually be defined as positivist. Miller (1999) explores this issue further in relation to clinical psychology, and emphasises the importance of defining the concept. With the previous caveat in mind, broadly speaking positivism asserts that: science should be concerned with observable facts; the methods used within the natural sciences should be applied to social sciences (e.g. quantification, and the formulation of general laws); and science is objective and value free (Barker, Pistrang & Elliot, 2002).

### *Realism*

Realism claims that an external world exists independently of our representations of it; this position holds that a belief is true if it matches reality, otherwise termed the correspondence theory of truth (Searle, 1995). Representations include perceptions, thoughts, language, beliefs and desires. They include all the ways in which we could or do, know and experience the world and ourselves (Nightingale & Cromby, 1999). Realist ontology states the world is made up of structures and objects that have cause-effect relationships with each other (Popper, 1963). Realism asserts there are many perceptions about a single, mind-independent, reality (Krauss, 2005; Healy & Perry, 2000). In this sense it recognises there are differences between reality and people's perception of reality and could be described as having elements of positivism and constructivism (Healy & Perry, 2000).

### *Relativism*

Relativism rejects the above principle, and argues that any such external world is inaccessible to us in principle or practice. A relativist ontology questions the 'out-there-ness' of the world and emphasises the range of interpretations that can be applied to it (Willig, 2001). Like many doctrines, relativism encompasses a number of views, the common theme of which is that some aspect of experience, thought, or even reality is relative to something else.

### *Social Constructionism*

Social constructionism is the position from which this research has been approached. It could be said to combine realist epistemology and relativist ontology. This would postulate that language, culture and time in history mediates experience. In other words our perception and experience does not reflect a fixed and knowable reality, but is one interpretation of the above conditions.

Knowledge is thus socially constructed and there are many ways of describing an experience, and therefore of understanding it (Burr, 2003). Rather than being “a singular and unified position...it is...an unfolding dialogue among participants who vary considerably in their logic, values and visions...there is substantial sharing, but there is no single slate of assumptions to which all would adhere. ” (Gergen & Gergen, 2003, pp.2).

Social constructionism can be placed among “recurring epistemological debates between those who see knowledge as somehow grounded in reality (e.g. Locke and Hume) and those who see it as, in part at least, a product of human mental functioning (e.g. Spinoza, Kant and Nietzsche)” (Edley, 2001, p. 435). The focus on language or the ‘turn to language’ meant people started to question the notion that there was a straightforward link between words and the world; and to explore how the ways we talk about and represent ‘reality’ impacts on how this ‘reality’ is perceived and constructed. This enabled a deconstruction of the dominant concepts underpinning psychological knowledge (e.g. Parker, 1992).

A common misconception of this approach is that it implies the world is purely textual and does not exist outside of discourse. This mistake relates to the assumption that “when social constructionists state ‘there is nothing outside of text’, they are making an *ontological* rather than an epistemological pronouncement; that is, a claim about what the world is actually like” (Edley, 2001, p.437). This reading of social constructionism often stems from the following that, “meanings are constructed by human beings as they engage with the world they are interpreting. Before there was consciousness on earth capable of interpreting the world, the world had no meaning at all.” (Crotty, 1998; p.43). However, that is not to deny that “the world had no substance in it whatsoever... (rather) that it consisted of ‘worldstuff’.

But the properties of this worldstuff had yet to be represented by a mind" (Humphrey, 1993, p.17).

The 'social' in social constructionism, does not just relate to those interactions with people but also natural or physical realities, (although there are debates within this approach which may disagree) all meaningful reality is socially constructed. The world is viewed through our culture; it "brings things into view for us and endows them with meaning and, by the same token, leads us to ignore other things". (Crotty, 1998; p.54). Thus research from this perspective may be involved in "investigating how context and interpretation (including those of the researcher) influence our experience and understanding of the world". (Yardley & Marks; 2004, p.4).

### *Hermeneutics*

Social constructionism is an example of hermeneutic construction. Hermeneutics is a term given to theories of interpretation (See Ricoeur, 1970 for further elaboration). Hermeneutic approaches reject the 'correspondence theory of truth' rather they state that as a person describes or understands their experience, there necessarily involves an element of interpretation of that experience. It argues that humans are essentially meaning-making. Within research this process has been termed the double hermeneutic (Smith & Osborn, 2003). This refers to the way the participants are trying to make sense of their world; the researcher in turn is trying to make sense of the participants trying to make sense of their world. The hermeneutic circle refers to the circularity of understanding. The researchers' perspective, pre-judgements and understanding initially shape their interpretation of a phenomenon. This interpretation interacts with the phenomenon, the interpretation is therefore open to revision and elaboration as these areas of pre-

judgements are revealed and evaluated (Finlay, 2003; Tappan, 1997).

The issue of epistemological definitions and the interpretations of different positions are fraught with contradictions (Martin & Sugarman, 2009; Michell, 2003). There are proponents of each position that adhere to strict versions of their stance, and others who could be considered to move further along, what might be described as an epistemological continuum or dimension. The main point arising from this relates to the importance of researchers to not only state their epistemological position by name, but to define what they mean by this (their interpretation).

Many of the debates outlined in the background literature stem from differences in ontological and epistemological positions. These debates relate to the historical dominance of positivism within psychology, and the equation of the research methodologies stemming from this perspective with quality, science and evidence. For those whose perspective may be more in line with post-modern, constructive and interpretive perspectives, the emphasis within guidelines on methodologies which stem from a more positivist origin is questioned. It is not that these perspectives are in opposition, rather both may approach research in different ways, asking different questions, however both are seen as valid and may contribute to 'knowledge' in unique ways. That certain methodologies and epistemological position(s) retain a dominant position is arguably where the call for a re-examination of the definition of science and the extension of the concept of evidence stems from.

My epistemological position, as stated earlier, comes from a social constructionist perspective. From this perspective when considering the history of clinical psychology for example, notions or

beliefs about the role of the psychologist have changed over the years (Pilgrim & Treacher, 1992), the profession has adapted and defined itself accordingly; it is a product of its time. As such, concepts such as science and evidence are socially constructed and do not represent 'fixed' truth, what may determine which definitions are given more weight or primacy may relate to dominant ideologies (Smail, 2006). It is therefore interesting from my perspective as a researcher how current clinical psychology trainees understand and construct both their role, and models which feed into this role, such as EBP and the SPM. This is particularly interesting given recent developments within the UK that may potentially move the platform for the profession.

### **2.3 Participants**

Inclusion criteria were that participants were in their final year of clinical psychology training in the UK, no exclusion criteria were identified.

### **2.4 Recruitment**

All third year trainees from three doctoral courses were approached. It was envisaged that due to their greater experience of clinical practice and their current or subsequent experience carrying out a doctoral piece of research, they would have more experience to draw on when considering the research area.

The information sheet (see Appendix 3) was emailed to the various course administrators who passed the details on to all members of the third year cohort. Included were suggestions for date and times to carry out the focus group (this was arranged around the trainees teaching day when all potential participants would be in the same locale). This strategy was employed partly to make the process easier (rather than trying to arrange suitable times

with six trainees after their agreement to participate) and partly due to time constraints. To encourage participation the trainees were also informed there would be a raffle held at each group where a £30 book token could be won.

The justification for conducting focus groups at more than one university, stemmed from the assumption that the local university 'culture' (including teaching, emphasis on particular theoretical models etc) may influence trainees constructions of EBP (Pilgrim & Treacher, 1992). This is hoped to provide a greater breadth and depth to the data gathered.

## **2.5 Method of data generation**

Focus groups are usually convened on the basis of some shared attribute such as professional role, or locality (Barbour, 2008). Previous research in this area has included mixed professions; researchers have identified several limitations of this. These include that each profession may have a different 'culture' which may influence their understanding of and relationship to EBP. As a fellow third year clinical psychology trainee and researcher, I was interested in exploring EBP and its related issues with fellow trainees. Other researchers have also highlighted this as a relevant research area (Luebbe et al, 2007).

The researcher's role is to draw information from the participants regarding the research focus of interest or topic. The focus group format is intended to encourage participants to speak freely and the dynamic nature arguably allows for richer data. This group dynamism has been described as a "synergistic group effect" (Stewart & Shamdasani, 1990), wherein the interaction between participants stimulates the discussion.



Focus group use has developed independently of particular qualitative paradigms (Barbour, 2008), which has been counted as one of the strengths of the approach, as the type of analysis depends upon the theoretical framework of the researcher. The method can be used either within an 'essentialist' or 'social constructionist' framework (Wilkinson, 2008).

#### *Advantages of focus group interviewing*

Advocated as a flexible method, it can be adapted to suit the nature of the research question(s) and the needs of the participants (Wilkinson, 2008). It has been suggested that the meanings and answers arising during group discussions are socially constructed rather than individually created (Berg, 2004); hence focus groups offer an opportunity to observe the co-construction of meaning in action (Wilkinson, 1998b). As previously mentioned, the goal in focus groups is to let people 'spark off' one another, ideally opening dimensions and nuances that any one individual on their own may not have thought of, thereby potentially exploring the topic more deeply (Barker, Pistrang & Elliot, 2002; Rubin & Rubin, 1995). Linell, Wibeck, Adelswärd and Bakshi (2001) describe this as: "The group is a think-group, in which cognition is going on in the minds of members, but this happens largely in and through interaction; individuals with some kind of common background stimulate each other to develop thoughts and arguments" (pp. 253). This method is advantageous in that it allows the opportunity for aspects relevant to the area or issue to be raised that the researcher may not have previously been aware of (Hesse-Biber & Leavy, 2006). Focus groups can encourage people to collectively address topics to which, as individuals, they may have previously devoted little attention (Barbour, 2008). This aspect was pertinent as during informal discussions with fellow psychologist acquaintances (not involved in the research), the general feedback

was that they had not really considered the topic areas in any great depth.

Proponents of focus groups count as an advantage the reduction of the power imbalance traditionally found with the interviewer/ interviewee relationship (Montell, 1999), wherein the researcher or interviewer is ultimately privileged as the authoritarian voice (Frey & Fontana, 1991). They may be more appealing or less threatening than individual interviews as there may not be the expectation that each individual will answer every question. Focus groups compared to interviews are considered more naturalistic, in that they typically include a range of communicative processes, such as arguing, persuasion, challenge and disagreement (Wilkinson, 2008).

#### *Limitations of focus group interviewing*

Traditional interviewing may allow a more detailed exploration of content information than is possible in a focus group context. However, inevitably this depends on the aims of the researcher. Some research suggests that focus group interviews do not produce more or better ideas than an equivalent number of one-to-one interviews, and may in fact produce fewer ideas than individual interviews (Fern, 1982). The difficulty with this claim lies in whether quantity of ideas is desirable, and how the quality of an idea is defined. Focus groups are also potentially limited in terms of the influence of power dynamics which may result in the more dominant members' views being expressed. There is also the potential for participants to give socially desirable responses which may not be such an issue in individual interviews or other methods of data collection. There is also the danger that as a group view emerges, alternative views may be suppressed (Asch, 1951). Practical and organisational constraints may also pose potential difficulties in that finding a suitable location and appropriate date and time can make

organising the group more complicated than organising interviews with individuals for example (Puig, Koro-Ljungberg & Echevarria, 2008).

In summary, focus group methodology was chosen as it was envisaged that the very strength of the focus group format; that a good focus group can stimulate debate and discussion between participants, would enable a deeper exploration of the research area than individual interviews.

## **2.6 Focus Group Schedule** (See Appendix 7)

The focus group schedule was developed through discussions with the research supervisor and through an exploration of the literature on EBP, the SPM and the IAPT programme. In devising the focus group schedule Wilkinson (2008) recommends making sure the questions flow logically, that it provides the opportunity for a variety of viewpoints to be expressed, and it allows participants to raise points which may not have occurred to the researcher.

Pre-testing the focus group questions has been highlighted as being just as important for this format as in other interview formats (Morgan, 1995). As such the focus group questions were discussed with the research supervisor and piloted with psychologists known to the researcher. This led to a reduction in the number general questions to be asked, as given the time-limit of around an hour it was not feasible to have too many, this is consistent with advice from Krueger & Casey (2000) who recommend allowing 10-20 minutes per question.

## **2.7 Procedure**

As stated above participants emailed the researcher with their agreement to be involved in this research; at this point they were

asked if they required any additional requirements to attend the focus group, such as a room with ease of access (no additional requirements were necessary). At the beginning of the session the purpose of the group was reiterated (as recommended by Berg, 2004) and any questions answered; group rules including mutual respect and confidentiality were discussed, and the finish time was confirmed with participants (as recommended by Wilkinson, 2008). The rooms were arranged in a circle with the recording equipment placed in the centre (Gillham, 2005).

The main topics and questions to be covered were used as a general guide for the group discussion (see focus group schedule, Appendix 7), this was used flexibly and active listening techniques, reflection and paraphrasing were used to allow the group to explore the issues. There were some participants who were quieter and open questioning such as "what does everyone else think?" were used to encourage participation from all members, as was using a person's non-verbal cues to illicit participation (such as, "I can see you nodding, does that sound like something you agree with?").

## **2.8 Ethical Considerations**

Prior to carrying out the focus groups the wider literature was searched and Hesse-Biber and Leavy (2006) provide extensive guidance on conducting focus groups with ethical awareness. Some of the issues considered related to the interactional nature of focus groups such as considering how to handle and deal with participants that may be visibly worried or distressed by opinions aired and general group dynamics (Wilkinson, 2008). This was not the case during any of the focus groups carried out and as previously outlined group dynamics were managed via facilitating the involvement of all members of the groups.

The researcher when discussing the ground rules included confidentiality (on the part of the researcher and the group members), and expected standards of conduct in terms of respect for alternative perspectives. Participants were informed about what would happen to the recordings (that they would be transcribed by a third party, and stored at the researchers' university according to- and in line with- university guidelines) and any questions answered.

In order to ensure participant confidentiality was maintained, the transcriber signed a confidentiality statement (see Appendix 6). The audio recordings were transferred to CD format; they were labelled with the date and time of the session and no other identifying information.

## **2.9 Method of analysis**

Following the focus groups the audio-recordings were transcribed by a paid transcriber, (this was due to time constraints). A number of methods were considered prior to the decision to use thematic analysis; these will be briefly outlined below before a more detailed description of the method chosen, thematic analysis.

### *Narrative Analysis*

Narrative analysis is concerned with "the human means of making sense of an ever-changing world" (Murray, 2008, p.111), and views narrative (the stories, or "organized interpretation of a sequence of events" Murray, 2008, p.113) as not just ways of seeing the world, but ways of constructing it (Riley & Hawe, 2004). Narrative is seen as "central to how we conceive of ourselves, to our identity. It is through narrative that we not only construct a particular connectedness in our actions but also distinguish ourselves from others". (Murray, 2008, pp. 113). Narrative is said to have the function of bringing order and structure to disorder; in story telling

the disorganised becomes organised and through this meaning is created. Although group narratives can also be explored, these are the narratives that particular collectives tell about themselves (Riley & Hawe, 2004).

### *Discourse Analysis*

The term 'discourse analysis' (DA) does not refer to a single method; there are a variety of versions and positions which would broadly sit within this camp. DA has been defined as; "an examination of language use – the assumptions that structure ways of talking and thinking about the topic of interest and the social functions that the discourse serves" (Powers & Knapp, 1990, pp.40). Discourse analysts suggest the world can be read in an unlimited number of ways, and that language, rather than being a way of representing reality, actively constructs it. Willig (2008) describes this as "people agree on what it is they are talking about, but they disagree about why it happened (attributions) and whether or not it is a good thing (attitudes)." (pp.163). Rather DA argues that attitudes and attributions are aspects of the discursive construction of the object itself. Rather than remaining stable "people's accounts, the views they express and the explanations they provide, depend upon the discursive context within which they are produced...what people say tells us something about what they are *doing* with their words (disclaiming, excusing, justifying, persuading, pleading, etc.) rather than about the cognitive structures these words present" (Willig, 2008, pp.163). The focus in discourse analysis is therefore on how people use discursive strategies or resources and what are the results of this. The action orientation of talk is attended to with a focus on how people manage issues of stake and interest. Foucauldian DA is concerned with language and the role it plays in the construction of psychological and social life; discourses can facilitate, limit, enable and constrain what can be said, by whom, when and where (Parker,

1992; Willig, 2008). Discourses, therefore, can “make available ways of seeing and ways of being (and can be) strongly implicated in the exercise of power” (Willig, 2008, pp.172). DA has been criticised on the grounds that: “Self is studied only in terms of individual, discursive acts which perform various social activities such as presenting a certain image of self, excusing and blaming. This results in a conception of self in which ‘subjective experience...is made so context-dependent, so fluid and flexible, that there seems to be little beyond a personal psychology which is moment-to-moment situated experience’ (Augoustinos & Walker, 1995, pp.226)” (Crossley, 2007, pp.133).

### *Grounded Theory*

Grounded theory is concerned with theory development (Holloway & Todres, 2003) and has become a popular method in psychological research (Payne, 2007). This method is “characterized by the use of theoretical sampling, constant comparative analysis, theoretical sensitivity, memo writing, identification of a core category and the concept of ‘theoretical saturation’”. (Webb & Kevern, 2000, pp.801). Grounded theory in its early days was predicated on a positivist epistemological position wherein hypotheses from grounded theory could be empirically tested and methods of verification were considered to require external objective procedures (Payne, 2007). This has evolved into more of an interpretive approach over the years (Strauss & Corbin, 1990). The epistemological tensions within this method have been commented on, in that a realist position is taken as the grounded theory inductively reflects participants’ accounts, yet constructivism is employed as it is the researcher who is creating and interpreting data to create theory (Henwood & Pidgeon, 1994).

There were several reasons why this approach was not chosen, primarily due to sympathising with the critiques outlined below. Grounded Theory has been criticised for its claim to ‘ground’ its

assertions; it is suggested that this is “a metaphor for some implicit assumptions about the mind of the researcher and about social reality, what we can know about it, and how we can arrive at that knowledge; ‘Ground’, with its intimations of solidity and fixity, simply does not mix with ‘construction’, with its contrasting intimations of the tenuous, the mutable, the interpreted” (Thomas & James, 2006, pp. 769).

Thomas and James (2006) continue with a critique of grounded theories claims that what it produces is ‘theory’ (which has also been explored elsewhere, Allan, 2003); and ask whether theory is about bringing ideas together or is it related to more positivist and functionalist expectations about explanation. Does grounded theory aim to explain or understand? This question is raised in relation to the assertion that “there is no ground, no hidden truth residing somewhere in the data ready to inscribe itself, (rather)...meaning is constructed by the interpreter. The interrelationship between interpreter and interpretation is indissoluble”(Thomas & James, 2006, pp.780). I also agreed with some of the critique of grounded theory, that the notion of ‘bracketing a priori assumptions’ may not be realistic or essential (Lyons, 2007); rather acknowledging these and exploring how they have shaped both the journey into and through the research may make for a more open and credible research report.

## **2.10 Thematic analysis**

Braun and Clarke (2006), state that TA can be used by those originating from an essentialist and constructionist paradigm; what is important is that researchers make their position explicit. This recommendation links into debates regarding how qualitative research is evaluated, one of the criterion suggested has been transparency in all aspects of the research process, including stating



the epistemological position from which the research has been approached.

In terms of what is considered to be a theme, there are no guidelines for example on frequency of the theme arising in the data. Prevalence does not in and of itself determine the relevance of a theme. Rather researcher judgement around 'keyness' of a theme will depend on whether it "captures something important in relation to the overall research question" (Braun & Clarke, 2006, p. 82).

The process of identifying themes can be an inductive or deductive process. The former involves coding the data without trying to fit it into any pre-existing coding frame, or from the researcher's preconceptions, and derives directly from the raw data (Braun and Clarke, 2006). The latter is drawn from existing theoretical ideas the researcher brings to the data. However, while approaching the data with an 'open mind' so to speak, the researcher will undoubtedly be influenced by her theoretical and epistemological stance.

Themes can refer to the manifest content of the data (such as the mention of a particular term), or it can refer to a more latent level (when a term may be implicitly referred to), and often analyses refer to both (Joffe & Yardley, 2004). Within semantic analysis the process moves from mere description to interpretation, the significance of the patterns, their broader meanings and implications are considered often in relation to previous literature. Analysis at the latent level "identifies or examines the underlying ideas, assumptions, conceptualisations, and ideologies that are theorised as shaping or informing the semantic content of the data" (Braun & Clarke, 2006, p.84).

Analysis is a recursive procedure, wherein the writing is an integral part of the analysis. Braun and Clarke (2006) describe thematic analysis as a six-phase process. Phase one involves thoroughly familiarising oneself with the data, which where possible includes transcribing the data, reading and re-reading it and beginning to make initial notes on meanings and patterns. Following this phase two entails the production of initial codes from the data, which include aspects the researcher finds interesting. These are 'the most basic...element of the raw data...that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis, 1998; p. 63). Coding can be done a number of ways (highlighting extracts, post-it notes), however, what is important is that all data extracts are coded and collated together with each code.

Phase three requires the analysis to move into the broader area of theme development. The list of codes is sorted into potential themes, with codes being able to be placed in as many themes as they are relevant to. It is necessary to see how the codes may combine to form an overarching theme. A recommended tool is the use of a visual thematic map. This can plot initial ideas about the relationship between codes, between themes and between different levels of themes (overarching themes and subthemes within them)' (Braun & Clarke, 2006, p.89-90).

Phase four moves the analysis into refining the themes, these should 'cohere together meaningfully, while there should be clear and identifiable distinctions between themes' (Braun & Clarke, 2006; p. 91). The coded extracts are reviewed to see if they form a coherent pattern, and revised if they do not. The analysis proceeds to establish whether the thematic map produced thus far captures the meanings manifest in the data set as whole, the recursive nature of the process means recoding may be necessary at this stage.

Phase five entails defining and refining the themes to form the final analysis. The data extracts that constitute each theme are organised into a coherent account. This stage of analysis identifies what is of interest about each theme and why, these also need to relate to the overarching 'story' in relation to the research aims. The above description is a necessarily brief outline of the process involved in using thematic analysis as described by Braun and Clarke (2006).

Thematic analysis is subject to the same criticisms as qualitative research as a whole, which mainly centre around how to evaluate qualitative research, the issues involved in this debate will be addressed below.

### **2.11 Evaluating qualitative research**

This chapter will outline common criteria by which research may be judged, it will highlight how quantitative and qualitative methods may frame their quality assessment in slightly different ways; guidelines for evaluating qualitative research will be explored; this chapter concludes with the quality criteria employed within this research. Research evaluation typically includes attending to issues such as objectivity, reliability, validity, and generalisability; each of which will be considered in turn.

#### *Objectivity*

Quantitative research (in the search for truth) generally, may seek to eliminate or minimise bias in the form of the researcher; objectivity is desirable and may be considered to add weight and authenticity to the research findings. This is also tied to replicability, reliability, consistency and stability (Brink, 1991; Madill, Jordan, & Shirley, 2000). Qualitative researchers however (do not view the aim of research to be about identifying truth), view the researcher as inherent in the whole research process; they endorse acknowledging

the position of the researcher and an open exploration of how this has shaped every aspect of the research.

### *Reliability*

In terms of reliability, which is generally considered to relate to replicability (if the same measurement or task is repeated under the same conditions it will yield the same results, Winter, 2000). The possibility of being able to produce objective, reliable knowledge within the social sciences has been questioned (Danziger, 1990). This can be problematic for some qualitative researchers who "...deny that replicability is either useful or possible in situations concerning highly complex and transient circumstances: namely those that involve the lives, thoughts and behaviours of actors" (Winter, 2000; p.3). It is also prudent to note that the heterogeneity of the qualitative research field requires equally flexible methods of evaluation. Yardley (2008) acknowledges that most qualitative researchers believe that different people have equally valid perspectives on 'reality', which are shaped by their context, culture and activities. However if this view is upheld and "there is no one 'true' perspective on reality, then which perspective should be used to evaluate the validity of a study?" (p.236). She elaborates further on this difficulty, highlighting that each qualitative methodology is based on different assumptions and employs different procedures, and questions whether one method of evaluation would be appropriate considering such diversity.

### *Validity*

The previous point raises the notion of validity; most definitions of which relate to the concept of accuracy, and whether the research achieves what it set out to, and whether it measures or access's that which it intended (Hammersley, 1987). Parker (2004) suggests that validity rests on a mistaken view that different ways of representing phenomena will necessarily be presenting the same thing. Winter

(2000) broadens the debate and states “validity is not a single, fixed or universal concept but rather a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies” (pp.1). As such it cannot be extrapolated from or categorised within a particular project, rather the “validity measure can be applied differently depending upon the researcher’s beliefs as to what stage of the research process is in need of validation” (Winter, 2000, pp.3). Conceiving of validity in these terms enables the concept to adapt according to the context within which it is employed.

### *Generalisability*

A further measure of quality is that of generalisability; Yardley (2008), states that both quantitative and qualitative research are interested in generalisability, as there would be little point if the findings in one situation had no relevance to any other. In quantitative research this is generally addressed by using representative samples of populations. For qualitative researchers ‘theoretical’ or ‘logical’ generalisations of their findings are desirable (Johnson, 1997). From this perspective it would be hoped that the insights from studying one context would prove useful in other similar contexts.

### *Triangulation*

This refers to the use of multiple researchers, research methods, sources or other theories in order to assess the consistency of the findings (Flick, 1991). This often has the intention of ensuring thoroughness and/ or confirming the analysis makes sense to other people. This can be achieved by comparing the coding of two or more researchers whereby convergence is considered evidence of accuracy and objectivity (Madill, Jordan & Shirley, 2000). Triangulation could be seen as an attempt to arrive at a clearer view or an explication of

what appears to different vantage points (Parker, 2004). Triangulation can operate by acting as an “agent for reflexive awareness, for an enhanced understanding of how research findings are constituted” (Bloor, 1997, pp.49).

Many of the above quality criteria have originated from a positivist and quantitative research perspective and simply translating the criteria to the evaluation of qualitative research is not considered appropriate (Healy & Perry, 2000). Alternate terms such as credibility, consistency, transferability and comprehensiveness have been put forth (Lincoln & Guba, 1985; Mays & Pope, 2000). This has led some to call for separate specific guidelines for evaluating qualitative research (Elliot, Fisher & Rennie, 1999).

### *Qualitative Research Guidelines*

The introduction of guidelines has been met with a mixed response; one concern with such proposals is that “the drive to create concrete guidelines for qualitative research (may have the aim of) creating absolute standards for certainty of knowledge-claims, which is problematic epistemologically (from some perspectives)...because absolutes and universal laws are only possible within the natural science mind-set” (Walsh-Bowers, 2002). Barbour (2001) fears that while the aim of these may be to enhance overall rigour and ensure thoroughness, if used prescriptively it may serve to limit research and result in formulaic responses to both conducting and evaluating research. However, Parker (2004) suggests “the criteria for good research are guidelines that are closed enough to guide evaluation and open enough to enable transformation of assumptions” (pp.95). The issue of coherence has been raised by others and refers to whether the question, epistemology, method, type of analysis and write up are internally consistent; the extent to which it ‘hangs together’ whereby there are ‘no abhorrent contradictions’ (Madill,

Jordan & Shirley, 2000). Other terms have been employed, such as 'trustworthiness', 'relevant' and 'plausible' (Denzin & Lincoln, 1998; Winter, 2000). It has further been recommended that while there may be general criteria, each researcher must interpret them in light of their own methodology and aims; good practice has been considered as outlining which criteria are appropriate for judging that particular piece of research (Harper, 2006).

Parker (2004) outlines four "open questions about quality": what counts as good? is it because it corresponds to the norms of established scientific study, it improves the lives of participants, or it poses interesting questions; who should it be for: should it be accessible to those outside of psychology, should it add to the body of knowledge for other researchers, participants should gain something from it; what counts as analysis? A careful redescription using some categories from a particular framework, the discovery of something that can be empirically confirmed as true, or the emergence of new meaning; what is the role of theory? Professional jargon, an antidote to commonsense, or the space for thinking about something afresh (pp.97). Parker (2004) claims good research will consider these questions and position itself in relation to them. This process of the researcher being active and present in the process and clearly articulating their position relates to the issue of reflexivity; indeed many of the points suggested above relate to this aspect which will be explored below.

## **2.12 Reflexivity**

A common point of convergence in discussions regarding criteria for qualitative research is that of researcher reflexivity. This can be seen to run throughout recommendations and is broadly an attempt to make explicit the process by which the researcher came to frame their questions, select their methodology and analyse their

data. Reflexivity, by making perspectives and assumptions explicit, is considered to add to the credibility of the research (Schram, 2003).

The concept of reflective practice and of being a 'reflective practitioner' permeates clinical psychology discourse, although what this entails is open to interpretation (Chinn, 2007; Newnes, 2006). Reflection in the context of clinical practice may broadly be considered to involve a process of considering (among others) which factors may be influencing the therapeutic relationship, and what aspects of the therapists' inner and outer world may impact on the outcomes of the intervention. One of the aims is for an increase in self-awareness and also a more detailed understanding of the client. Chinn (2007) suggests there is an assumption that this process can bring us closer to a truthful understanding (a problematic position for those whose epistemology may question the possibility of this). Reflexivity is considered to be subtly different; this involves "appreciating one's social position, preferences and desires and considering how they impact and constrict what can be known" (Chinn, 2007, pp.13; Rolls & Relf, 2006). Reflexivity has been separated, by some, into two aspects, epistemological and personal reflexivity.

### *Personal Reflexivity*

Personal reflexivity refers to the way the researcher recognises how their own experiences, motivations, political stance, and agendas contribute to what goes on in work with clients (Chinn, 2007). These aspects rather than being conceptualised as obstacles to be removed or overcome; are considered to be valuable resources that can enrich the interaction with clients. Research is always carried out from a particular standpoint and acknowledging ones social status, gender, class and ethnic position and how these might influence and shape the research adds to a more thorough and considered piece of work



(Burman, & Parker, 1993). The researcher by reflecting on their position within the research means that, "readers can judge the content in the context of the perspectives and assumptions by which it was shaped" (Marshall, 1986, pp.195). Depending on where one positions oneself will necessarily influence how reflexivity is approached; a postmodern and social constructionist position may consider the above aspects but also acknowledge the intersubjectivity inherent in the research interview. That is to say that the data is constructed in a conversational exchange between the researcher and participant(s), therefore the researcher is both inside the research, while simultaneously trying to reflect on the research. The social constructionist position in research; "enhances the possibilities for us to be aware of what our utterances and actions achieve" (Lewis, 2003, pp.234).

#### *Epistemological reflexivity*

Epistemological reflexivity has been described as a "critical examination of our own techniques of sense making" (Potter & Weatherell, 1987, pp.87). This allows the research to be considered or evaluated in terms of its internal consistency and coherence. In other words is the epistemological position to the research questions, to the method of data collection, analysis and write-up congruent? This involves considering "the ways in which the research questions have been defined and limited what can be found, how the design of the study and the method of analysis have 'constructed' the data and the findings, how the research question could have been investigated differently and what different understandings might have arisen as a result." (Chinn, 2007, pp. 15).

### *Evaluative measures for this research*

The quality criteria considered pertinent to this research include those cited by Elliot, Fisher and Rennie (1999); and Braun and Clarke (2006), who provide a 15-item checklist of criteria for a good thematic analysis. This includes criteria at all levels from transcription to coding (themes are internally coherent, consistent and distinctive), to analysis (analysis tells a convincing and well-organised story about the data and topic), and the written report (there is a good fit between the described method and the reported analysis).

This research aims to satisfy the criteria of 'coherence' by ensuring a consistent approach framed within a social constructionist perspective, this should be evident from the language and concepts used being consistent with this position. The research is 'owned' wherein themes do not 'emerge' but rather I actively construct them and my position and perspective are clearly present. Triangulation was employed whereby themes were discussed with the research supervisor, this served to ensure I could justify my analysis within the data; this process also achieved a reflexive purpose in that it allowed a different perspective to broaden the analysis. I have also ensured that the analysis is presented alongside verbatim transcript excerpts as a means for the reader to judge credibility and coherence (Corden & Sainsbury, 2006; Fereday & Muir-Cochrane, 2006). In order to further establish the credibility of the research, I also took into account one of the criticisms of focus group research being that the write up does not make reference to the group situation, I attempted to address this by including extracts which highlight the interaction between participants, what have been termed "interaction quotations" (Idvall & Rooke, 1998). It is intended, and hoped, that (as Elliot, Fischer and Rennie, 1999, recommend) the overall report will resonate with the reader.

## **Chapter 3: Extended Analysis**

### **Chapter 3.1: Thematic Analysis**

This chapter will further elaborate the method of analysis, including a description of each phase of the analytic process and culminating in further detail of the main themes generated.

"Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes (the data) in rich detail (and) frequently it goes further than this and interprets various aspects of the research topic" (Braun & Clarke, 2006, pp. 79). Prior to conducting the analysis a number of decisions had to be made about the level of analysis (following the guidance by Braun and Clarke, 2006). Analysis can be inductive, or 'bottom-up', or theoretical and 'top-down'. An inductive approach is data-driven, it locates its themes firmly in the data; the researcher does not try to fit the themes into their own pre-existing conceptions. Although within this it is recognised the researcher will still be approaching the data from their own theoretical and epistemological position. Alternatively, a 'theoretical' thematic analysis is motivated by the researchers' theoretical interest in the area; this is more explicitly analyst-driven (Braun & Clarke, 2006). While an either-or approach may be taken, researchers have also utilised a hybrid approach and combined both forms (Fereday & Muir-Cochrane, 2006; Filiault & Drummond, 2008).

The analysis in the current study could be said to utilise both inductive and deductive modes of data analysis. A "top-down" approach was used in the sense that the questions were in part drawn from previous literature; and a "bottom-up" approach in that the themes were drawn directly from the data and a pre-existing framework was not used. Analysis did not proceed until all three focus groups had been conducted; this decision was based upon the

desire for the themes to be data driven and not imposed or driven by the researcher; had potential themes been identified prior to all groups being conducted, the researcher may have been drawn to eliciting such themes from subsequent groups, however unintentionally (unlike grounded theory which would take a converse approach).

### **Chapter 3.2 Phase one: Familiarisation with data**

As highlighted previously, Braun and Clarke (2006) recommend a six stage process to conducting a thematic analysis, this procedure was followed for this research. The first phase involves transcribing the data, as previously indicated this was carried out by a paid transcriber. I discussed the level of detail with her prior to commencing the transcription, and we agreed on a standard convention (such as three dots to indicate a pause, brackets to indicate when audio is unclear). There are a number of transcription conventions which have been developed for specific forms of analysis (such as conversation and discourse); thematic analysis does not require the same level of detail as the aforementioned approaches and it is not necessary to transcribe prosodic, paralinguistic or extralinguistic elements, and transcription can be flexible. Upon receipt of these I checked them in detail with the audio-recordings and made any changes such as correcting misheard words and acronyms. This was the first phase requiring reading and re-reading the data, including noting down initial ideas. Following each focus group I made notes recording salient aspects I felt particularly captured or illuminated a certain area.

### Chapter 3.3 Phase two: Generating initial codes

Prior to commencing this stage, each transcript was given a reference of F1, F2 and F3 (to stand for Focus group one, two and three; they were numbered in the order I conducted them) this was to respect confidentiality and to avoid identifying the university affiliation. The transcripts were each incorporated into a table (see Table 1) this allowed line by line numbering for reference purposes and space for recording the initial codes on the left. Initial codes are described as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p.63).

Initial code	Ref'	Data: Transcript
Client feedback is evidence	112	Mmm Yes because I guess that's evidence
	113	based in the sense of getting the feedback is
	114	the evidence

Table 1: Example of initial coding

Following this a detailed reading of each transcript was carried out. I read F1 and developed initial codes, repeating this for F2 and F3. Supplementary notes were made during this process of any patterns and potential themes I felt connected these codes.

### Chapter 3.4 Phase three: Searching for themes

Following stage two I had a long list of codes, I now began to see how I could arrange them and group them together under overarching themes. I organised these around the three main areas covered within the focus group, evidence-based practice, the scientist-practitioner model, and Improving Access to Psychological

Therapies, accordingly three main data sets (Braun & Clarke, 2006; Filiault & Drummond, 2008) were compiled; this utilised a deductive mode of analysis in that these three data sets were developed from the researchers' interest in the area. Within each data set an inductive thematic analysis was conducted. I will illustrate the analytic phases in detail using the EBP data set, however, for the following data sets I will just present the final thematic map related to each area, rather than demonstrate each refinement. In terms of phase five of the analysis, I will provide an example again for EBP, but in order to avoid repetition, subsequent elaboration of the themes will be evident within the write-up. I will use the term 'participant' and 'trainee' interchangeably as this reflects both of their positions.

### **3.5. Evidence-Based Practice**

#### **Interview Question 1: What does evidence based practice mean to you?**

When determining how to group the themes in relation to this aspect of the data, there seemed to be two aspects, participants initially responded with ideas related to the concept of evidence and different forms this embodied. This then progressed to attitudes towards the concept of EBP and consideration of its utility and limitations. As a consequence two separate thematic maps are included.

The thematic map (figure 1) shows the initial main themes I felt captured responses around the concept of evidence:



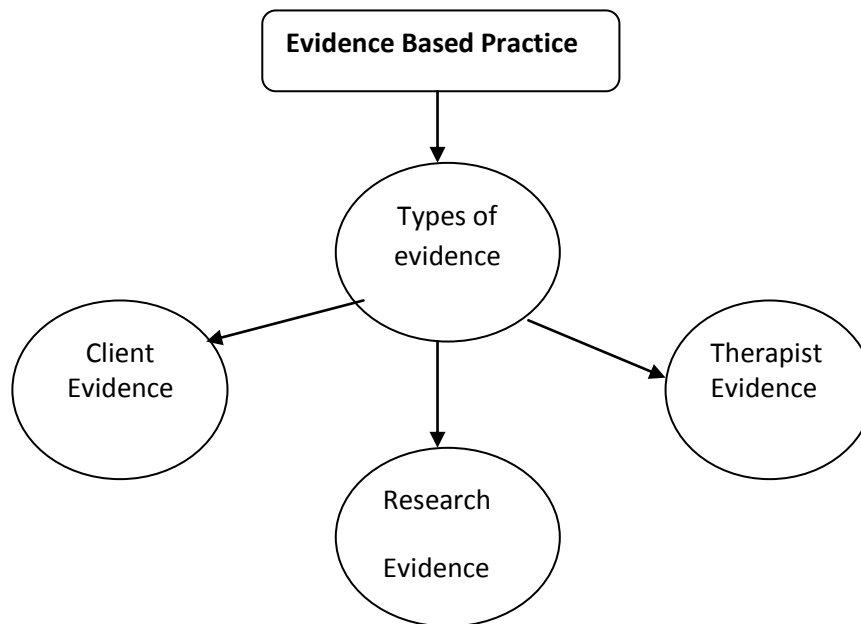
**Figure 1:** Initial thematic map, showing six main themes.

### **Chapter 3.6 Phase four: Reviewing themes**

At this stage I reviewed all the codes that constituted these themes and following Braun and Clarke's (2006) recommendation, reviewed these using Pattons' (1990), dual criteria for judging categories. This suggests there should be internal homogeneity (all codes and extracts should cohere within the theme) and external heterogeneity (there should be clear distinction) between themes. At this stage I decided qualitative and quantitative research could be collapsed into research evidence as a single theme as participants considered both aspects as constituting EBP albeit in slightly different definitions. Practice-based evidence contained elements that were incorporated into therapist evidence and evidence from the client, in that client evidence was viewed as influencing intervention in the moment and at a more immediate service level; while other aspects

of practice-based evidence were conceived as relating to development of the therapists internal evidence base.

Consequently figure 2 shows the revised thematic map, showing the final three themes:



**Figure 2:** Final thematic map, showing three final main themes.

### **Chapter 3.7 Phase five: defining and naming the themes**

This stage involves a process of reviewing the extracts for each theme, and organising them into a “coherent and internally consistent account” (Braun & Clarke, 2006, p.92). It is suggested that the content and scope of each theme should be able to be summarised in a few sentences. Braun and Clarke (2006) recommend theme names should be concise and immediately give the reader a sense of what the theme is about. An example of this is the theme ‘Therapist evidence,’ this refers to: any code which related to participants description of evidence therapists use to guide their practice, which would not come under any of the other theme headings. Below is an illustrative example:



Ref	Data extract	Initial Code	Theme
F3: 99- 102	What you said earlier about having a model you work with in therapy and then seeing that it really works, in this way and the other, so you'd do it again	Own experience and observations are evidence that guides practice	Therapist evidence:

**Table 2** Example of phase five: Defining code and naming theme

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### **Chapter 3.8 Phase six: producing the report**

This phase involves providing an account of the story the data tells. This section onwards contains the remainder of the analysis; I will present the themes relating to EBP, followed by those in relation to the SPM and finally those related to the IAPT programme.

#### **Responses to the first question: What does evidence based practice mean to you?**

Firstly, analysis of the data related to evidence-based practice was considered in terms of what constitutes evidence, there were three themes related to this as shown in figure 2, verbatim quotes are used to illustrate these. I have tried to include as much context to the quotes as appropriate, so the reader can gain a greater appreciation of how the extract relates to the theme identified.

As indicated previously there were two thematic maps created under the overarching EBP theme (types of evidence and attitudes towards EBP); I will begin by presenting the 'types of evidence' theme and the three sub-themes which constitute it (research evidence, therapist evidence and client evidence).

### *Types of evidence*

All focus groups considered evidence to be multifactorial; participants conceived of evidence as deriving from a number of sources all of which influenced their practice to varying degrees.

### *Theme 1: Research Evidence*

This theme incorporated any reference to research which was considered to constitute EBP. All three focus groups began with aspects which would fall under the 'research evidence' theme, specifically initially referring to RCTs, empirical evidence and the quantifying of data; NICE guidelines were identified as producing a hierarchy of evidence with the RCT at the top.

*Certainly when I hear the word or the phrase evidence based practice, if I'm in my clinical setting on placements and I've got a client coming in with maybe a new area that I haven't worked in before, that for me would be going through the journal papers reading what's out there, what models and theories have been RCT'd or whatever, and I suppose NICE guidelines would be a big thing for me as well in terms of evidence based practice (F1: 19-27).*

*NICE guidelines probably comes into mind and they have like a hierarchy, don't they...so I guess for me it tends to mean basing what you do with your clients around evidence that's*

*been generated through research. As a phrase that's probably what it means to me (F2-6-8; 12-17).*

This is consistent with previous research presented in the literature review, that practitioners often equate EBP with RCTs (Luebbe et al, 2007).

However, the concept of evidence was perceived to incorporate more than these initial ideas:

*I see it as being something that's a bit broader than that really, or that it should be, that's kind of how I would think about it (F2: 49-54).*

*I think of it as more broad to the point of any research that's been done specific to an intervention (F3: 27-29).*

*Evidence based practice I think of as like the research that's been published and actually done, that it, that will inform practice; but there are lots of other evidence based practice that more loose, more looser forms of it I guess, that informs, that probably gets used more (F3: 119-124).*

This expanded definition incorporated case studies, single case and qualitative research evidence. While these were considered to be equally valid forms of research that were as significant for practice as the RCT, there was a distinction drawn between different methodologies with a sense that one was more 'scientific' and by definition more respected or acceptable. This led to uncertainty about whether utilising such methods was appropriate, as this following interchange illustrates:

*You know, a case study that you read could be really helpful when you're working with someone, but then how does that look to someone else if you say, 'oh yes I'm basing my practice on this one paper' (... )but it all combines, I think that's the thing, it's difficult...*

*...What happens if you try something in a session that just works? But do you know what I mean, is that evidence based?*

*...It is, yes, well it will count as evidence but it's not respected and this is going back to what is evidence base? and the predominant model is scientist, positivist, RCTs (F1: 1394-1421)*

The question of who would not find the use of such evidence acceptable is interesting; there was sometimes a direct reference to an assumption that training course markers would not deem this appropriate (when referring to case studies), but there was also a question of professional credibility and a fear that this may be questioned if other forms of evidence are used to base an intervention upon. This perceived uncertainty also highlights further factors that impact on clinician decision making, how am I going to be judged and can I justify what I do, will my justification be accepted? This uncertainty and confusion about the acceptability of practice and whether it would be classed as 'evidence-based' is captured in the following extracts:

*I find that a difficult one to answer just purely because I've had so many different experiences (mmm) given whichever supervisor I've been working with, that I don't know whether I always do work in an evidence based way, because if that*

*means referring to NICE guidance, then no I'm not, because I don't always do that. (F1: 1374-1381).*

*I guess you can say your practice is evidence, but is that the evidence of your last work that you did, I used this before or I'll have a bash at that again, or are you saying evidence has to be NICE guidelines or Cochrane review? (F3: 74-78).*

There was a sense that a narrow conceptualisation of evidence was not representative of current constructions of what evidence means, and that practice, and ways of viewing practice, have changed and there may be many ways of constructing it:

*I think it just depends from what perspective you're viewing evidence based practice and how you would define it (F3: 238-241).*

*There's some good evidence and research out there, I think it's just about not taking it as objective and the one truth and just about being critical of it, or coming from a critical perspective (F1: 1861-1865).*

*I personally think that evidence based practice is a good thing, but it's got its limitations and it's not just the whole, it's some part of what other things that can be done that's useful (F2: 190-193).*

*You know it's a basis isn't it, that very much needs expanding on (F2: 290-292).*

The above extracts implicitly refer to a more postmodern perspective whereby there is not the search, or expectation for universal truth,

rather there are multiple truths; this is one of the fundamental difficulties with EBP in the wider literature as; “EBP has its’ roots in the modernist paradigm within which...the truths it establishes are superior to other world views” (Lyotard 1984, in Laugharne, 2002, pp.53-54). The participants’ construction of EBP appears to reflect this; there was a sense that there was a ‘new’ way of viewing evidence which included critical reflection.

### *Theme 2: Therapist Evidence*

‘Therapist evidence’ captured the cumulative aspect of knowledge through experience, which was considered to act as a kind of internal individual evidence base.

*there is that acknowledgement that there is a knowledge base that’s ever increasing (F2: 336-339).*

*because we’ve tried other things and you have your own personal experience of what works, you can’t help by being informed by that (F3: 552-554).*

*You know, I think you would use that clinical knowledge that is your evidence because you’ve worked with clients (F1: 1181-1183).*

Participants placed value on their experience, and while believing the evidence base in terms of research was a starting point, there seemed to be an overriding idea that practice incorporates and utilises evidence from a number of sources, including the psychologists own knowledge base. This was interesting as I felt the participants were implicitly beginning to question knowledge, and how we acquire, accrue and construct it. There was a perception amongst participants that as knowledge and experience were gained

this would result in less reliance on guidelines and more autonomous practice:

*When you've worked with different models and you've seen change in whatever way the model thinks about change, and seen it happen, then it becomes a bit less relevant what the guidelines say (F3: 537-542).*

This aspect related to the position as a trainee, that the greater the experience the greater store of knowledge one has upon which to base decisions. Trainees highlighted this as their expectation of how their practice may change over time;

*that clinical experience and judgement might be based on evidence but it may not be something you can actually grab and say that's what I'm using, it becomes more automatic almost rather than a conscious decision maybe...*

*...Mmmmh*

*...That comes back to that intuition and gut feeling (sounds of agreement) (F2: 390-403).*

*So I think that probably what I'm anticipating is that as time goes on my confidence will gain and I will be able to hopefully make some decisions that I'll feel confident enough and I don't know what I'll base those on, that's the thing, because I'm not there yet. But I do believe quite strongly on profession intuition and you know hunches and that is something that I put quite a lot of faith in really, rightly or wrongly, so I hope that that will somehow be built in too, you know it's about feeling confident to do that, considering all the ethical processes with that. (F2: 339-356).*

This extract further alludes to the idea that there is a 'right and wrong' way of doing things. Decision making is considered to become internalised and automatic with experience and led by intuition, and while considered positive, there was a perception that maybe 'intuition' would not 'fit' with the current conceptualisation of 'acceptable' evidence upon which to base decision making. Interestingly the mention of ethical processes implies that intuitive practice may not be ethical.

### *Theme 3: Client feedback as evidence*

The final theme, 'client evidence', incorporates all extracts that referred to using client feedback to inform and shape practice:

*Yes and that is so important isn't it in clinical work it's the, it's the self report, well, if that shows improvement you know sort of in their day to day activities or functioning, it doesn't matter what the numbers say, it's what they are actually saying (F2: 765-772).*

*It would be nice if was an accepted part of evidence based practice, peoples' actual self report (F2: 800-803).*

*If it works for the client then that to me is all that matters, it shouldn't have to be, you know, randomized controlled and all that kind of thing, but maybe that's like a scientific cynic in me type thing? (F3: 294-298).*

This direct client feedback was considered to be practice-based evidence as it was used 'on-line' to guide a particular intervention with a particular client; it was utilised to tailor the intervention as it progresses and evaluate its effectiveness.

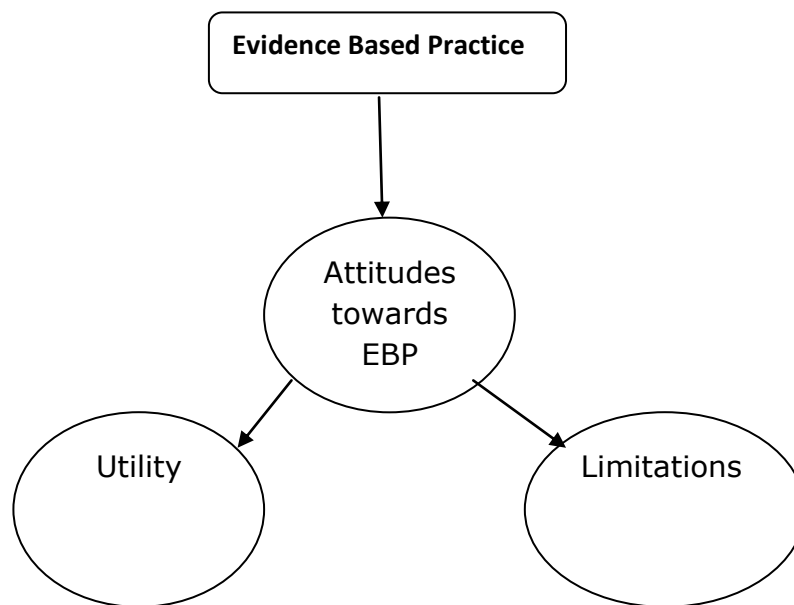


Despite participants describing how they used client evidence, there was again the perception that this was not 'proper' evidence, which again returns to the construction of evidence (by the participants) in the main as stemming from research. There seemed to be a divide between how participants constructed how they *should* be practising and how they were *actually* practising; in that their practice was driven by client factors and therapist evidence more than EBP. This seemed to create tension both in terms of how others would view their practice and also influenced their attitudes towards EBP, which leads into the following themes.

### **Chapter 3.9 Attitudes towards evidence-based practice**

The staged process described above was followed for the remaining thematic analysis. Rather than describing in detail the phased processes for each area (which may be repetitive), I will only present and describe the final thematic map and accompanying narrative for each of the research areas (The scientist-practitioner model and IAPT).

The second thematic map related to EBP, encapsulated attitudes towards this concept. The main themes related to this are illustrated in figure 3 below and include the perceived utility and limitations of the model.



**Figure 3:** Thematic map showing two main themes related to attitudes towards EBP.

### **Theme 1: *Utility of EBP***

This theme incorporated aspects which referred to the perceived function of the model; subthemes include; EBP as ensuring ethical practice; as a means to allocate resources; and providing containment.

#### *Subtheme i) Ethical Practice*

This sub-theme captured explicit and implicit references to notions of ethical and desirable practice; there was a dichotomy between what participants viewed as desirable practice and the view felt to be espoused by the EBP 'movement':

*I think as well, saying about the importance of evidence based which it obviously really isn't ethical to go out there and try what you like without any reason for doing that, but then again*

*if you stick rigidly to what the evidence says and what the guidelines say, then you're missing out on the person and obviously every depressed person doesn't present in the same way, although there's obviously a lot of similarities. And you could argue that it's unethical to treat anybody the same way as well isn't it (F2: 275-291).*

The idea of following the evidence base as an ethical responsibility arose several times; it was interesting that not following the evidence-base was considered unethical, when participants also described how they sometimes didn't follow it (due to rigid implementation also being viewed as unethical if it did not take into account client factors). This highlights the participant's confusion with trying to integrate the different (and sometimes contradictory) perspectives they hold in relation to these concepts and their implications for their practice. The inconsistency can be understood as partly relating to the view of 'evidence' as something which isn't a static or clearly definable term. The uncertainty also linked into how others would view their practice and construct evidence:

*. ...also that different audiences may influence...*

*I think you need to be able to justify what you're doing...*

*...Yes*

*...It depends again who you're justifying that to I suppose, as to what argument you would use or you know what evidence you would use (F3: 594-601).*

Ethical practice appeared to be conceptualised as being able to explain and justify treatment decisions; this wasn't restricted to being able to say 'I followed X guideline'. Rather it was about individualised and tailored interventions, and following guidelines was equated with

'applying a model to a person' and essentially the antithesis of person-centred collaborative practice. However, while EBP could equally be perceived as being conducive or aversive to ethical practice (primarily related to which definition of evidence was employed), a positive aspect was the containment it could give to trainees.

*Subtheme ii) Providing containment and identity*

This theme drew together references to the function that guidelines and following a particular model can have for both trainees and the wider profession, in terms of providing security, containment and professional identity; this also connected to notions of professional credibility:

*Does it give you a little bit more confidence in that you don't feel so much like you're winging it, that OK, well the guidelines for depression is this, this and this, 'Oh I'm doing all that, that's fine, that's given me confidence'...*

*...and respect from people, because that's one of the questions you're often asked, 'Oh what's your affinity with, what's your particular tool bag contain?', and if you go, 'well actually I just take a bit of everything', you're going to be seen as somebody that's really got no idea of what they're doing...*

*...Yeah that's it...*

*...Wishy washy (F1: 629-648).*

*Following these models (...) it helps, it helps the clinician feel contained em, and it helps the customer feel that they are getting something, they're buying something and they are receiving something (F1: 257-260).*

*It's about respect isn't it, you have an affinity with the model because it gives you containment, security, gives you em, respect I suppose and acknowledgement from others (F1: 666-670).*

This theme could be considered to expand upon current conceptualisations regarding the different motivating factors which influence 'compliance' with EBP and how these factors too, are not static. In particular there was an expectation and desire to move from needing containment to greater confidence and autonomy as experience grew:

*I think whilst you're training probably, probably it feels safe and secure to perhaps follow guidelines and follow models, but I would imagine that as you get more confident within the role and more clinically experienced that you feel more able to digress from that (F2: 327-335).*

The final sub-theme within the overarching utility theme related to resource management.

#### Subtheme iii) *Necessary to guide resources*

This sub-theme incorporated those extracts which contained any references to the financial aspects associated with EBP. The perceived utility of the model connected to commissioning factors and the need to invest in interventions that were considered effective:

*I think I can see why the guidelines were produced and I can see why they have to, you know, the culture of the NHS that we work in, this huge black hole for money, and there has to be some kind of way of deciding what we do. But the idea of*

*evidence based practice seems to be very very exclusive really, and the NICE guidelines doesn't really seem to get to the essence of providing therapy for people with mental health difficulties, and does miss a lot of what it is about by going through that quantifying process of finding things that were measurable (F2: 106-122).*

*I think in a way you can't ignore that commissioners do want the bigger picture, that actually you can understand completely why people say we need to know what you're doing's effective (F3: 582-585).*

*Yeah but if I'm going to pay for you to do the therapy then I want you to show me that it works (F3: 300-301).*

However, while there was recognition that there needs to be some means of regulating and distributing financial resources; the question of basing such decisions on current research evidence was considered problematic. This in the main refers back to the perception of current dominant constructions of evidence as being narrow, which leads into the perceived limitations of EBP.

## ***Theme 2: Limitations of the EBP model***

This theme subsumes attitudes towards EBP that in the main related to the potential limitations of the model, this included two subthemes; EBP perceived as restricting practice, and EBP as failing to acknowledge the role the supervisor plays on trainees practice.

### ***Subtheme i) EBP perceived as restrictive and directive***

The misgivings toward the model were captured within this theme and include extracts which expressed such. Participants spoke about viewing EBP with scepticism and cynicism; this was due in part

to the perceived flaws of all research; and believing the model presents a simplistic and unitary view of both evidence and practice, which are actually quite complex and varied:

*Evidence, it just suggests to me that someone is saying that evidence, 'this is the right way', and this just doesn't fit with my ideas about how the world works really, that there is no just one way of doing something, and prescription, and er kind of having options open to me is a much friendlier and less closed down way, a freer way of doing things (F2: 541-551).*

*it's like there is so much bias in what's looked at anyway it makes you a bit cynical about evidence based practice (F3: 568).*

*I think for me it feels as though it favours quantitative studies more than qualitative studies. (F2: 31-34).*

*I think a lot of the evidence base, from my understanding, it does look at effectiveness and efficacy, but it doesn't look at the person's experience, so it's like number crunching (F2: 179-183).*

*When I looked at the NICE guidelines and then looked at the articles the research was citing, it just seemed really like it was pointless to base it on that evidence because there were just so many reasons why that evidence was no good at all. Like the authors were part of the company who had written the programme and therefore were standing to benefit hugely financially from it, and massive restrictions on the people who could take part in it, which just cut out huge proportions of the population. It just wasn't realistic then in practice, and*

*numerous things like that made me very sceptical about that really. (F2: 79-98).*

The previous extract taps in to debates about the transferability of research to practice, and is consistent with previous research findings which highlighted this as one reason why practitioners may not utilise such findings; namely due to considering research to be far removed from their everyday practice. The question of who is conducting the majority of research and why, contributed to the distrustfulness of EBP:

*I think the more you hear about the NICE guidelines and the drivers, and the commissioners for the NICE guidelines, and are all funded by the drug companies aren't they a lot of them...that doesn't necessarily reflect what is best (F3: 544-547).*

Participants felt resistive towards a model they viewed as potentially constraining their practice; this was considered to be the polar opposite of how they conceive their practice should be and in line with their expectations from training.

*I'm very open to evidence based practice as long as it's a more flexible model, but at the minute it just seems like it's quite restrictive to me. It seems like you have to do it this way or not at all. (F3: 760-763).*

*I just think, I don't know, I don't feel that I want to be told exactly what I should be doing. I feel that having had all this training you should be quite flexible about things and bring your own kind of style and approach to it as well (F2: 721-729).*



A further perceived limitation of the model is that, as well as seemingly to discount or ignore therapist and client evidence, it also appears to neglect that there are other sources of influence on clinicians practice, such as the clinical supervisor.

*Subtheme ii) Supervisors influence on clinical practice*

The final subtheme within the limitations of EBP assimilates extracts referring to the role of the supervisor in guiding trainee practice, particularly in relation to the evidence-base.

*I was just thinking that as well that often when you get those kind of cases that are more complex where there are lots of different things going on or whatever, I always think that when I've talked about it in supervision, that my supervisor's are obviously more experienced at knowing what kind of approaches might work in that situation. (F2: 300-310).*

That supervisors may not model practice which explicitly incorporates utilization of the evidence base was put forth:

*Do you not think though, at the end of the day, especially as trainees, when you go on your placement and you've got a client, you're not really going to the knowledge base, it's whatever your supervisor wants you to do, or whatever model you're supervisor uses. You know it's not very often that your supervisor says, 'oh let's look at the evidence', you know, 'well you could do CBT, or you could do this or you could do that'. It would be like, 'No here we do CAT or here we do CBT'*

*Yeah...*

*Yeah that's true, that's actually the choice at the moment you have. (F3: 413-428).*

There is also a sense or assumption, that to implement practice informed by guidelines would, by definition be practice that isn't client led, as the following extract highlights:

*But sometimes you do get supervisors who will say, like for example I was just chatting to one of my supervisors yesterday and she was saying, 'Oh well, I know you want to do CAT', she said, 'this client does seem like she might respond better to CBT'. So there's that consideration that you can't just throw a model at someone and use it all the time, and I don't know if that was just one supervisor, but I've come across other supervisors who've done that as well, who've considered (...) and even though they might have a preference for a certain way, they wouldn't use it just for anyone, they would think about it and whether it was appropriate (mmm's of agreement from other members of the group throughout)...*

*...But they're almost looking at it from the perspective of the client again rather than the evidence, they're thinking, 'this client fits in with CBT', I think, not 'Oh the NICE guidelines say CBT and therefore...' (F3: 430-459).*

Luebbe et al (2007) find it worrying that the students in their research stated supervision was one of the main guides of practice, and state; "if students' primary source of information comes from formal academic support...they are apt to be at a great disadvantage later in their professional careers when these sources will no longer be readily available." (pp. 653). However, this could be reframed and understood as a necessary and inevitable part of a training process

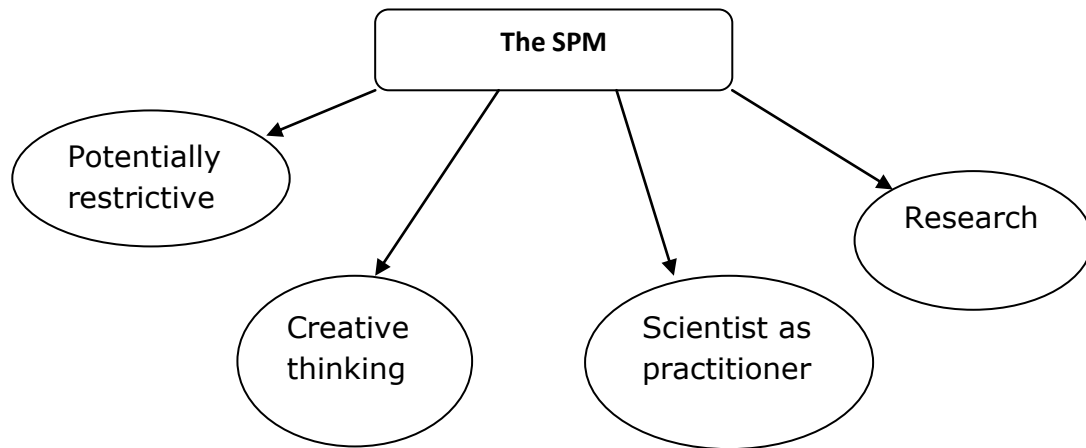
indeed, as indicated in this research, trainees envisaged lifelong learning and accumulative knowledge through practice which would allow them to build confidence and their own knowledge base.

While the questionnaire design of the Luebbe et al (2007) research prevented participants from elaborating on reasons for this; the current research has provided possible considerations for the higher rating of supervision over research evidence. Namely, that trainees may feel directed by their supervisor, and if the supervisor doesn't explicitly model directly referring to the evidence base, then trainees may not do so either. Trainees may feel that due to the power dynamics (they need the supervisor to pass them as competent on the placement) they are more likely to acquiesce to the supervisors suggestions. However, an alternative and equally valid explanation, which draws in factors mentioned earlier; is that the supervisors' greater experience is respected and consequently their guidance is followed. The above extracts also suggest that client factors are used to guide the intervention over practice guidelines (also consistent with Lucock, Hall and Noble, 2006).

### **Chapter 3.10: The scientist-practitioner model**

#### **Interview Question 2: What does the scientist practitioner model mean to you?**

The next themes concern talk around the SPM; there were four main themes created around extracts pertaining to this area. These were; the perception of the model and viewing it as being potentially restrictive on practice; a wider conceptualisation as reflecting a more creative approach to practice; that being a scientist is about a way of approaching practice, and as having research as an essential element of the model.



**Figure 4** Thematic map showing four main themes related to the Scientist- practitioner model.

*Theme 1) Potentially restrictive*

The first theme grouped together perceptions of, and attitudes towards, the SPM. This theme encapsulated concerns with the model in that it can imply 'doing-to' as opposed to 'doing-with'; this construction of the SPM was perceived negatively and felt to be quite limited, and limiting, in terms of what the scientist practitioner is, and does.

*the first image that I get, is of somebody in a lab poking someone with electricity, but when you then start talking about the hypothesis being open to revision, that's a much friendlier way, you know, it encourages that curiosity about the person that your, and collaborative working with them...*

*...I agree with that, I think it feels much more prescriptive and less joint working, and less collaboration and just applying pure research to the situation and not taking into account all the*

*other variables; that would be a non friendly scientist practitioner. (F2: 437-456; 499-506).*

Interestingly, the above image evokes a 'natural science' connotation; experimental, laboratory based 'science'. This construction of the scientist practitioner is considered by the participants as 'unfriendly' and diametrically opposed to one who seems less rigid and works collaboratively. The initial image in the extract above seems to be referring to research and raises a curious question around how science is conceptualised (science seems to be seen as inhumane, clinical and cold, rather than something approached with curiosity and warmth) which seems to colour receptivity to the SPM model:

*I don't know why but I, and I think other people do as well, have quite a negative reaction to those words (EBP and the SPM), I don't know why. I think it's because, I think it's because we're told that we've got to do it in a specific way, that we probably resist that, and want to be a bit more flexible about it. (F2: 519-528).*

*I don't think the idea of evidence based practice and the scientist-practitioner is a bad thing, I just think if you apply it really rigidly without thought it can be quite a bad decision really, and I guess it leaves aside the fact that the most important thing I guess is the relationship, because you're not going to get anywhere unless you've got a relationship with somebody (F2: 562-574).*

The negative evaluation of both models was tied to perceptions of it as being quite dictatorial and autocratic; participants polarised this with a view of the SPM as being more acceptable if it were seen as

being more open, responsive and flexible. This led me to create a further subtheme from other extracts which seemed to encapsulate an alternate view of the SP as being conceptualised more broadly as a way of approaching practice.

### *Theme 2) Scientist as practitioner*

The second theme 'scientist as practitioner', referred to descriptions relating to approaching practice in a scientific way:

*Using our scientist skills to amalgamate and evaluate (F3: 1039-1040).*

*Isn't it as well, the stuff I was talking about, continuous cycle of assessment and evaluation as well as a scientist, you know, being a scientist during your practice. (mmmm) As well as I guess having the knowledge to critique a piece of research effectively. So to actually not just be fed outcome, you know, outcome results, but to be able to take them apart a bit and understand the nature of research and different parts of it and to be able to evaluate, to evaluate the evaluations (F3: 794-803).*

*I can see it as someone who will draw on evidence, but also theory to inform the approach, and actually use your framework of psychological reference, that is theory and evidence based to inform your work and being driven by that...*

*...and then vice versa, using their work to inform what they then go and research...*

*...yes, yes (F3: 780-789).*

The last extract brings in the oft cited perception that there is a gap between research and practice; however these participants explicitly

linked the two within the model and considered it to be a circular process.

### *Theme 3) Creative Thinking*

The theme 'creative thinking' related essentially to the problem-solving skills felt to embody the SPM including reflexivity and adaptability:

*we're capable of thinking on our feet and evaluating what we're doing and changing and being dynamic (F3: 652-654).*

*And it's about adapting and being flexible (F1:1185).*

*So the scientist bit and the evidence bit is more about sort of the framework of evaluating, more about evaluating what would be useful and what wouldn't in my eyes really (...) I'm very much for being more creative and flexible and individual, I'd hope (F2: 605-613).*

*Yeah and to reflect on everything you're faced with a client (...) every aspect of it together (F3: 807-808).*

These extracts appeared to emphasise the perceived importance of, and strength of, the model, as embodying a dynamic approach to practice. Scientist practitioners incorporate information from a wide area and have the skills to weigh-up the quality and significance of such information. This appeared to be a more 'friendly' version of the SPM, compared and contrasted with the rigid and restrictive model outlined above.

*There is something in there as well though, that after ten years of training or whatever, you don't want to just be following a manual (yeah, yeah). I think the reason we are so educated and paid so much money is because we're capable of thinking on our feet and evaluating what we're doing and changing and*

*being dynamic within the work we're delivering. It's not just about I have to follow this list of CBT (F3: 648-656).*

Participants seemed to view there as being two 'versions' of the model, one more palatable than the other; depending which version was employed influenced whether the model was considered acceptable or not.

The SPM was compared with that of EBP:

*I think evidence based practice fits into scientist practitioner because there's so much more that a scientist practitioner should do, apart from evidence based practice (F3:869-872).*

*I think (...) they are quite linked, I guess science and evidence sort of go together don't they, but I don't think they necessarily have to (F2: 514-518).*

While both models could be perceived as being potentially restrictive and in a sense static; the SPM was considered to incorporate more, and extend beyond, EBP by being inherently more reflective and adaptable and dynamic than EBP. This perception could feasibly link to professional identity and self interest and in some respects, survival; in other words a need to promote the model as including skills that set the clinical psychologist apart from other professionals (expanded in the following theme).

That science and evidence are not seen as being intrinsically woven together, may be related to earlier themes which highlight the differing sources of evidence as well as research evidence (therapist and client for example). However, research was still considered an essential aspect of the SPM, which is captured in the final theme below.



*Theme 4) The place of research in the model, and practice.*

The final theme encapsulated extracts that considered the role of research in the SPM model; both the act of conducting research, accessing research, but also the SP role in terms of dissemination of research.

*contribute to research on a general level and further the understanding of psychology and clinical psychology (F3: 815-817).*

*I think it's really (I might have sounded like a little bit cynical of science but I think I just question science and question the assumptions that are inherent in different scientific practices and stuff), but I think it's important we do research, I think you know, it's a key part of our role and I think it's definitely important to do that, but perhaps think about the way in which we do it and perhaps introduce new methods of doing it, qualitative and so on and so forth (F2: 832-841).*

Conducting research was viewed as being an essential part of the role; an opportunity to expand current dominant research methods, but also a means of distinguishing ourselves from other psychological therapists;

*I do ask myself why they should pay for me, and the reason they should pay for me, and the reason why they should pay for us, is because we've got the skills to go and look at the research, appraise literature, look at the evidence base, we can develop the evidence base. If we think something's crap we can go and do some research into it, and we will establish that it's crap if, do you know what I mean? I think that's more, although*

*it's not, you know ideal because we like our clinical work, but it's what sets us apart...*

*...yeah...*

*...the scientist stuff... (F1: 409-422).*

*I think as a group of professionals in order to survive and be stronger than what's out there...we need to be able to do something more and I think research is what we do, whether it be service evaluation or appraising the literature (F1: 1735-1742).*

However, there was also recognition that there are various factors which can inhibit the ability to carry out this part of the role, such as restrictions on time and other service demands that prevent such research:

*It does seem like a lot of places are contracted...to do research, but in the grand scheme of things it comes down to time and targets and everything else that we've kind of touched on. So I do think people do want to produce that evidence base but I think it needs to come from a higher level where resources are actually put in to enable psychologists to be able to do that because at the minute it's not really the psychologists doing the research it's the academics. (F1: 1770-1779).*

*I can see why people aren't doing as much, you know, you set out with high hopes about how much you'll do, but I can see why they're not, especially now when you seem to have to justify every hour you spend. In some services you have to write that down, and how many clients you see and things like that. It might feel like there's no time, space, for that. But like you say I think it's important to fit that in somewhere, maybe*

*talk to commissioners about that side of your role and sell yourself as doing that as well (F3: 843-853).*

Although personal reasons and past experience were also taken into consideration as to why research may not be conducted:

*I just think ethics puts people off research! I think after you've actually finished the thesis and it's all over...you need a time where you can break away from that...you think 'oh it was such an effort, it was such a difficulty' that it makes people resistant and also the lack of protected time impinges as well. (F2: 647-664)*

*I looked into this at a service I worked in, in (city)...and for a lot of people it was a fear of doing research, but also not knowing where to start because all they'd done was their thesis and it had been a horrendous experience, it was awful; it took a long time, there were so many hurdles, so many barriers. Why would you go and do that on your own again? (F1: 1802-1810).*

Nevertheless, participants considered that when assertions are made about the level of research being conducted by qualified psychologists, this tends to be a narrow definition of research, and that if a broader definition of research is assumed and includes audit and service evaluation then the level of research (while not necessarily published on a wide scale) may be higher than is currently appreciated:

*Or even the difference between national and service level research. I suspect a lot of psychologists engage in service evaluations and evaluate well on a local level what they're delivering. But that's not publishable necessarily, it won't feed*

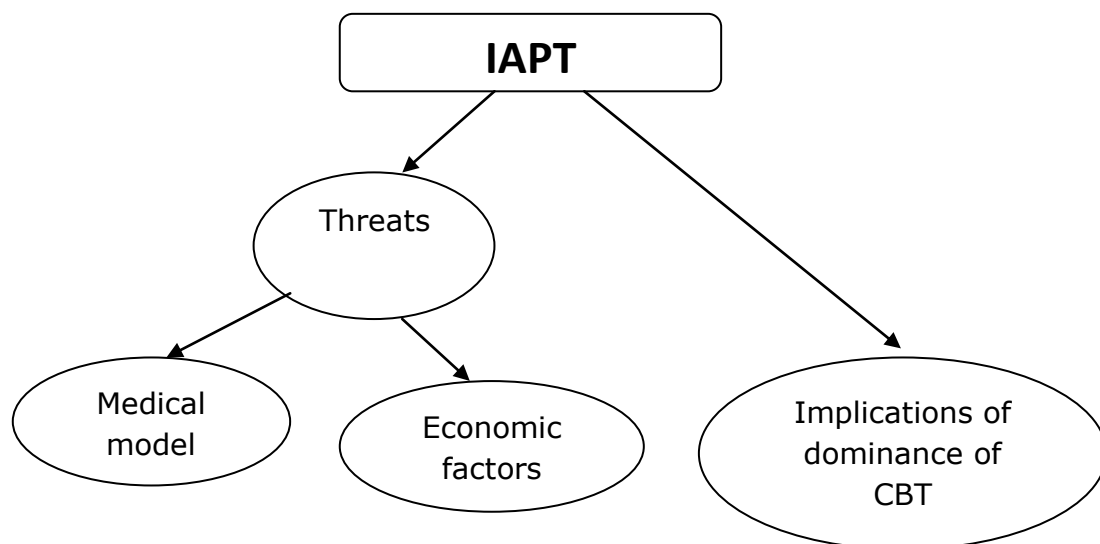
*into guidelines and theories, but you know, they are evaluating their service (F3: 855-861).*

This may be termed practice based research and its sphere of influence is essentially much smaller; but (in terms of proximal and distal factors mentioned earlier) may feel more relevant to the context of the practitioner.

### **Chapter 3.11 Improving Access to Psychological Therapies**

#### **Question 3: How does IAPT fit into current practice?**

This section relates to participants discussion around IAPT. There were two over-arching themes that I felt incorporated the content of the groups; perceived threats to clinical psychology arising out of the IAPT programme and the perceived impact of a focus on CBT (sub-themes are illustrated in figure 5).



**Figure 5:** Showing the main themes related to IAPT

## **Theme 1) Threats to clinical psychology**

IAPT was perceived as embodying a number of threats to clinical psychology namely in regard to the medical model, but also economic factors related to a value-for-money judgement. The perceived economic impetus for the programme also led to scepticism about the motivations for its construction.

### Subtheme i) *Economic Factors*

Financial factors were considered to be potentially a threat to the credibility and underlying motivation of the IAPT model. This also related to the wider culture of the NHS which has finance in mind in terms of cost-effectiveness:

*there is an element across the NHS like that because the NHS, you know, is a business and maybe IAPT has just highlighted that a little bit more (F1: 1077-1080)*

*Why would you employ somebody at 30 grand when you could have two IAPT therapists to do the same work...*

*...because we can work on a much broader level with a greater number of presentations (and not just thoughts and behaviours), at a service level, you know, we've got all the organisational stuff, we've got service development, neuropsychology, we've got the scientists stuff, research. It's whether people see that (...) or whether they just see the money (F1: 1270-1281).*

However, there was also recognition that it was important to know what was effective for financial reasons as highlighted within earlier extracts in section 3.8. The programme, while on the one hand has promoted psychological therapies and led to an influx of funding to increase provision; has appeared to increase anxiety regarding the

role of clinical psychology within the programme and the wider psychological therapy field. However, despite the increase in funding and recognition of psychological therapies; there was concern that the model underpinning the IAPT programme was essentially the medical model. This leads into the next threat sub-theme, the medical model.

### *Subtheme ii) Medical Model*

A further threat theme was identified as the emphasis within IAPT of the medical model and how this may not sit with psychological frameworks; they are considered opposing discourses:

*I think the NICE guidelines fit into a Health model, don't they, a medical model where if you give somebody a treatment this is the outcome, where as psychology doesn't necessarily always fit into that sort of framework (F2: 407-411).*

*If they're going down the medical (...) if they're sort of turning psychology into the medical model, and that's people within our own profession, I mean how much, what can we do about that, then it's a dispute within our own profession really (...) it feels like we're going backwards rather than forwards (F1: 183-188, 199-200).*

*When you're working within a medical model you need (...) they want evidence and their evidence is positivist, you know RCTs, that's what they want (F1: 558-561).*

Talk across the focus groups appeared to reflect on the perceived difficulties, differences and tensions between a medical conceptualisation and a psychological one. Psychological ways of working were considered by some to be moving towards a more medicalised approach, with concern about the implications of this. From the participants' position as trainees, there were various

pressures and vested interests felt to be promoting a particular world view; this included financial factors indicated above, but also the influence of their training course, particularly referring to academic assignments:

*Where's that scientist-practitioner you know, we're not allowed to reflect we have to follow that medical model yet again as we do with all the classifications, the mental illnesses or whatever, it's like saying, 'well we're separate, but we're still with'...*

*...But that also highlights even as trainees you're not given the opportunity to experiment as such, and try out techniques...unless there's a sound evidence base, whatever that is...*

*...I think it comes down to, as well though whoever's the opinion of the marker, because I used a model that was only, that came out in a book last year in my recent case study and that was accepted because I justified it. But again I think it comes down to the marker and their opinions on evidence base. So the marker who took on mine was very open to it, and because I justified it, it was fine. But if you think about other members of staff then yeah you would probably get the green pen throughout your work. Then again it's hard to generalise because again, everybody like, we've all got our own opinions on what's evidence based, they've all got there's as well (F1: 512-538).*

Here the SPM and the inherent reflexivity felt to be embodied within this, is contrasted with a view of the medical model as not including or encouraging reflexivity:

*Basically em, like a sort of scientific paradigm which says this is how you get proper evidence, this is the way and this is this and sometimes things like NICE guidelines will only take into account things from that particular paradigm, whereas within psychology I think there is new ways of thinking about things. So like for example thinking more reflectively, thinking more about like what's working, more person centred perhaps em (F3 221-230)*

The position of psychology as being in some respects separate but also bound to, and with, the medical model seems to hinder or constrain the putting into practice, of the broader definition of the SPM. This was considered to potentially result in various losses, including valued aspects of the SPM.

## ***Theme 2) Implications for practice of promotion of CBT***

This theme encapsulated talk around the perception that the IAPT programme is promoting a restricted view of psychological therapy by primarily advocating CBT. The implications of this for clinical psychology training were considered:

*As a clinician would you be happy coming out (of training) predominantly doing CBT, looking at no other therapy, looking at no other model, pure CBT?...*

*...No (lots of no's), but that's what's worrying about the fact now...there is a huge focus on it (F1: 301- 309).*

However, there was a sense that it was important to be able to utilise a CBT approach but that this evoked questions about the future of the profession:

*I'm thinking of, well going back to what's in vogue at the minute CBT, 2 years down the line it might be something*



*completely different so, you know, particularly now at this stage as trainees coming out into an area, I'm thinking ok well we have the confidence in CBT or whatever, well how long is that going to actually be in, you know how long is that going to be in operation for until someone else writes a report, fires it in the government changes their stance, NICE changes their stance again (F1: 224-233).*

This related to a fear that the perceived current focus on CBT was transitory, that it is related to political and economic factors (returning to an earlier theme) and what the implications for training in a single model might be. However, while talk seemed to indicate a desire to offer choice and a variety of therapeutic models and approaches, recognition of the difficulties inherent within that:

*It's considering them (the client) in a (...) 'what you've brought sounds like it might work, CBT might work', but rather than saying 'you choose CBT, CAT, Psychodynamic', I don't know that's probably confusing for people...*

While there was the perception that those promoting IAPT were essentially promoting prescribed practice (due to the focused on evidence-based approaches and therefore mainly CBT); there were mixed views about the programme. It was seen as a positive in that psychology has been given greater import, funding, and is more widely acknowledged within the general public as well as mental health services. But that it may promote a narrow perception of what psychological therapy is:

*I think NICE have been very very clever, or the government or whoever, has been very very clever in pushing CBT as this evidence base, you know I think if we went out now in the streets and surveyed a hundred people...*

*...They'd ask for CBT...*

*...I would say a good majority if you said 'have you heard of CBT?' they would probably say yes...so has that actually helped the profession of psychology? I think it, you know, has it? Has all that media publicity around this evidence base heightened the need for psychology?...*

*...It has, it has I think, that's where you have to turn around and say, 'I do like the fact that psychology is now there in the forefront of mental health, that makes me happy, because now at least people do have that therapeutic option whereas previously they didn't...but I think what disappoints me is that the psychologists involved in pushing it forward haven't remained critical (F1: 732-759).*

Therapy seems to be constructed (within the view of the EBP model) as very standardised and 'neat' in a sense, whereas trainees considered their practice frequently was not:

*I probably shouldn't stick my neck out (unclear), but you go to write up your case study and you're like, 'OK, let me just find some evidence for what I've done'..*

*(laughter) yes, yes*

*...it's very backward...*

*...you know if you've done CBT it's gonna be there...*

*...But then doesn't that beg the question, why don't we? Something must be wrong with the way we can access the evidence base, or the problem with the way the NICE guidelines, the inaccessibility of them...there's something wrong there isn't it? Why don't we, if we should and we know that we're meant to be driven by evidence based practice, it's*

*drilled into us, why in practice does that not happen, why is it backward like that? (F3: 467-489).*

*We said working eclectically, so you might be using CBT but you're probably going to take from other things as well, other things you know can be effective. I don't know that I've ever worked strictly CBT with anybody...*

*...or even any model, or any therapy (exactly). You know, how often have we, you know, gone 'right OK I'm just using this and nothing else', because I know I haven't. You take certain elements out of different things to suit the client (lots of agreement), and to suit the service and what you can feasibly provide in that service. Evidence base only goes a certain way (F1: 1604-1616).*

The IAPT programme, while raising the above concerns about the promotion of a single therapeutic model, inevitably connects to the wider debates about EBP and its relationship with, and applicability to, clinical psychology. This relates to the perceived loss of the use of a psychological formulation.

*as clinical psychologists we are trained to apply the most appropriate model to the problem that we see, and as it stands we're being constrained at the moment (F2: 150-152).*

*everybody with a certain diagnoses will get a certain psychological therapy, never mind doing the initial assessment and formulation and then deciding what's appropriate (F1: 208-212).*

*It's a human being, a human being is going to come with their life histories, their own life experiences, with their own sort of range of variables that are impacting on how they live or experience the distressing experience. I don't understand how*

*you can determine before; 'oh I've got a referral that's depression, right I know what I'm going to do now', it just doesn't work like that (F1: 687-700).*

The perception that people are treated like they are homogenous rather than heterogeneous links back to the perception that in advocating a particular therapy (due to research evidence) that this impacts on a view of how therapy 'should' be conducted; which may differ from therapy 'in practice'.

*Realistically we would probably all say we use CBT, but we would draw on a lot of other things, but that would have been the predominant model but because we know more we'll use that, whereas if you've only been trained in CBT that's probably all you'll use because you won't be able to draw from all those other things.*

*But also because you're not allowed to (sounds of agreement) F1: 1640-1648).*

*I think, coming back to the kind of evidence that the guidelines for evidence based practice to be based on again. I feel they tend to have pigeon-holed, they don't tend to be based in formulations they tend to be based on diagnoses, so this therapy has been shown to be effective for this problem and, rather than this therapy can be useful for someone who has a formulation that looks like this, it just doesn't work like that. (F2: 233-246).*

This perception that psychologists practice may be constrained and that tensions between different discourses exist, caused one focus group to reflect on what this might mean for them post qualifying:

*Maybe that's a big thing for our role is, will be, to inform, to do part of that process of informing people about what the*

*expectations are and what the nature...and how they're different from...we need to do that as a way of showing why we need the role...I suppose...*

*...it's interesting it throws up a lot of questions doesn't it (yeah, yeah) (F2: 927-936).*

## **Chapter 4: Extended Discussion**

This section provides a discussion of the main findings from the research, elaboration of the themes generated by the analysis, a consideration of the strengths and limitations of the research, the clinical implications of the findings and suggestions for further research.

### *Summary of aims and findings*

This study aimed to explore how trainee clinical psychologists conceptualise EBP and the SPM; these models have raised numerous debates concerning the implications of them for clinical psychology, particularly in light of recent service developments such as IAPT. The study wished to explore how these trainees construct the models and whether these constructions influence their receptivity to the models and if, and how, they influence their practice.

The findings revealed that initial reactions to the term EBP equated it with efficacy research, randomised controlled trials and NICE guidelines. This was considered to be the dominant definition and interpretation, and the version endorsed by promoters of the model. This version was considered to be quite restricted and restricting; participants own construction of the model was broader and considered to reflect more accurately their day-to-day practice. This construction of the model amalgamated a critical and reflective

use of research evidence, with therapist knowledge and experience, and was viewed as being more client led.

The EBP model was perceived as serving several functions; promoting the importance of ethical practice, guiding resources, providing containment and a sense of professional credibility to practitioners. Limitations of the dominant conceptualisation of EBP included a sense that it promotes a simplistic view of clinical practice and misses out the complex nuances of therapy; that it puts forth a prescriptive approach to practice that contrasts with a more palatable, flexible stance. Participants highlighted that there are other influences which shape practice beyond research, including the clinical supervisor, service structures and demands, and economic and political factors.

There were four themes created around the SPM, the first captured a view of the model similar to a view of the EBP model, that it could be perceived as restricting practice, and depending on how the model was constructed, this influenced trainee receptivity to it. Participants own view saw the scientist practitioner as a critical reflective scientist practitioner; someone who approaches their practice in a scientific way; science in this definition was viewed in terms of adapting practice in light of new information and according to client need, compared to a more directive top down approach. The SPM was considered to help define, give credibility to, and guide the clinical psychologist and help highlight the skills of the role and distinguish it from other psychological therapists. Conducting research was felt to be an important part of this but factors which can hinder this were acknowledged.

The recent IAPT programme has stimulated debate within the clinical psychology profession; talk within the focus groups around

this topic was captured within two main themes; the perceived threats to clinical psychology and the implications of the increasing focus on CBT. The increasing funding for psychological therapy and provision was considered a positive aspect; however, the training of psychological therapists who can deliver therapy for less money than clinical psychologists was a cause for concern. The implications for clinical psychologists were felt to be uncertain; the need to emphasise the many other skills of the clinical psychologist was felt to be paramount; this linked into the importance of the SPM as a means of promoting these abilities. The current dominant view of EBP was felt to be endorsing the medical model, with the IAPT programme assuming the same perspective and approach to practice. Participants felt part of the future role of the clinical psychologist was to promote a broader definition and interpretation of the EBP model, and to find ways of researching models and practice which has more practice relevance, therefore focusing on practice based research as a priority. Participants hoped this would influence the IAPT programme and widen the evidence base for models beyond CBT, and to encourage a more psychological framework centred on formulation and reflection.

#### **4.1 Elaboration and expansion of research themes**

##### *Differing constructions of evidence and science*

Participants initially equated EBP with efficacy research, this is consistent with previous research (Luebbe, Radcliffe, Callands, Green and Thorn, 2007; Corrie & Callanan, 2001). The broader definition espoused by the participants included all forms of research including qualitative; participants felt these too should be incorporated. This desire for an expansion of the types of methods considered to provide evidence is a common call within the wider literature (Morse, 2005).

While qualitative approaches have always been part of psychology, Willig and Stainton-Rogers (2008) chart the historical context of psychology to highlight factors which led them to be “marginalized and muted for the first 80 years of the 20<sup>th</sup> century” (pp. 3). The rise of behaviourism at the start of the previous century and the move to view psychology as the science of behaviour; is put forth as accounting for the dominance of quantitative research within psychology. This dominance “relegated any other method...to the realm of the unscientific” (Danziger, 1990, pp.107); and led to the perception that “reflection (was associated) with dangerous elements of subjectivity that ever threatened to contaminate experimental procedures” (Morawski, 2005, pp.80). Part of this drive for quantitative research stemmed from a “socio-economic demand for psychology to be more utilitarian – for it to generate knowledge which could be useful for managing society and its problems (in areas like crime...and mental hygiene).” (Willig & Stainton-Rogers, 2008, pp.4; Jones & Elcock, 2001). The end of the 19<sup>th</sup> century was also a period during which there was a notion of a “single philosophy of science - a single set of principles that underpin research” (Willig & Stainton-Rogers, 2008, pp.4).

It is evident within the focus groups that the initial dominant view of evidence is grounded in the view that quantitative efficacy research is equated with this model. However, while participants’ considered all research to be relevant, uncertainty was indicated about what constitutes ‘valid scientific’ evidence and whether other (bar RCT) methods could achieve such status. This question forms part of the wider debates in the psychological literature about the EBP model. As Feuer, Towne, and Shavelson (2002) contend; judgments about the scientific merit of a particular method can only be made in light of its ability to address the research question at hand. They state science is not synonymous with a specific method (e.g.,



randomized experiments); rather the question to be answered is what should determine the choice of methods. While they acknowledge that "RCTs, when feasible, are the best method for assessing causal relationships, but the rhetoric of evidence-based research seems to denigrate other research methods for studying important policy questions" (McKnight, Sechrest & McKnight, 2005, pp.558).

Participants highlighted that their construction and conceptualisation of the world, was not confined to a single view; that in terms of clinical practice there could be numerous ways of formulating and intervening that were equally valid. The perception that the EBP model promoted a restricted view led to negative reactions. Participants were uncertain whether evidence and science were automatically or inherently synonymous; this issue is further addressed by Willig and Stainton-Rogers (2008). They assert that the question of 'what is science?' is "more ambiguously positioned within qualitative methodology discourse" (Willig & Stainton-Rogers, 2008, pp.6). They state that; "Science does not have to be defined solely in terms of the hypothetico-deductive method. Other-qualitative-methods can be equally rigorous and valid. The identification of 'science' with hypothetico-deductivism is a relatively recent development (Popper, 1963). "'science' is an historical concept, and...arguments around the extent to which qualitative methods can be 'scientific' contribute to its definition and evolution" (Willig & Stainton-Rogers, 2008, pp. 6).

That these concepts are fluid, and change depending upon the context within which they are used and their merit judged depending upon who the audience is, was highlighted within the focus groups. The impact of this was that it was difficult for participants to identify whether their practice was evidence based, as what is considered evidence varies dependent on the above factors. If a positivist stance

or construction of EBP is taken, then they equated EBP in this sense with referring to NICE guidelines; if a more 'friendly, broader or reflective' version is utilised then practice would be influenced by drawing evidence from any source of research, client factor or therapist experience (or all of these).

As Bolton (2002) highlights; "'Evidence' was always an integral part of human reasoning and even of religious faith. Nevertheless, the answer to the question 'what is evidence?' has changed over the course of time. The nature of 'evidence' is not only historically shaped. It also depends on cultural circumstances, on philosophical and epistemological reflections and on disciplinary boundaries". (pp.11). Participants reflected on their experience of trying to utilise broader conceptualisations of the EBP and the SPM but that opposing discourses and factors in the wider context impacted on this. In particular they highlighted the medical model as exerting more influence and shaping both service delivery models (in terms of the IAPT programme; with the research underpinning it being diagnostically driven); and the psychologists ability to employ a psychological framework for formulating.

### *The scientist-practitioner*

The participants initially equated the SPM with a didactic approach to practice; construing it as something which limits the freedom of practice. Participants considered the term conjured images of experimental research, and of an approach which is directive; it dictates how the clinician works and does not encourage collaborative practice with clients. However, an alternative and more acceptable image was a SP who took a more flexible approach. Participants considered the critical-reflective-scientist-practitioner as

providing the framework for clinical psychologists to promote alternative perspectives.

The construction of the SPM had research as a central aspect. The role of research was captured across several themes both in relation to EBP and the SPM. This extended beyond simply carrying out research, and having the skills to critique research; but also as an approach to practice, which utilised client feedback to monitor therapy progress. They viewed this as researching their own clinical practice. Knowledge gained in such a first hand way was considered by participants to constitute their own personal ever-growing evidence base. Such an approach to practice is consistent with the Quality Assurance Agency (QAA, 2004) benchmark statement for clinical psychology which considers that, 'research activity is not simply about evaluation of effectiveness of treatments' (Dallos & Smith, 2008), but 'research includes the ongoing evaluation of assessment, formulation and intervention in relation to specific services provided' (QAA, 2004, pp.3).

One of the oft cited critiques of the SPM is that the majority of clinical psychologists do not publish in research journals (Harper, 2004). Dallos and Smith (2008) suggest that the low-output of research post qualifying (Cooper & Turpin, 2006) is due to trainees viewing research as something separate from practice; they advocate training which explicitly reflects and highlights the parallels and overlap between both activities as a means to address this. However, this research would suggest that for these trainees these skills are utilised in day-to-day practice and are embodied in their overall construction of what it can mean to be a scientist-practitioner. The practical constraints on being able to conduct research were acknowledged, including lack of protected time for research, and service structures which were target driven in terms of waiting lists;

it was also considered that many clinicians may not have the desire to conduct research.

Morton, Patel & Parker (2008), suggest the change of culture in foundation trusts will have most impact on what clinical psychologists can do in terms of research activity. Such trusts operate according to a business model wherein efficiency, cost savings and value for money are a priority. Such emphasis is likely to impact on the activities of the psychologist, with research not being seen as a priority. Kennedy and Llewelyn (2001) echo similar sentiments and state the fundamental difficulties of what they term the 'evidence-based-scientist-practitioner model' lies in the fact that clinical psychology is located in health-care within medicine, which has a different epistemological base and more power. However, participants acknowledged that research activity such as service evaluation and audit which is often not recognised; may still be carried out, and can actually have more of an immediate and relevant influence on, and for, the practitioner.

### *The critical-reflective-scientist-practitioner (CRSP)*

This term was created to capture all aspects the participants felt were essential to their role and their practice. The emphasis on the reflective and critical elements rose from the perception that the 'original' or narrow SPM neglects or omits these aspects, and may actually discourage such practice. Participants viewed this as resulting in 'restrictive' versions of the EBP and SPM which encourage a very simplistic view of practice; 'this person has X diagnosis, this means X treatment'. This was not perceived as reflecting the complexities of client presentation, or allowing for an alternative conceptualisation of the person's experiences beyond that of diagnosis (this was particularly prevalent in talk around the

implementation and ethos of the IAPT programme). Such a reflective element is considered by Harper (2004) to be more consistent with a social constructionist perspective; this is evident within the focus groups who emphasised the importance of acknowledging multiple 'truths'.

The term reflective practitioner is predominantly traced back to Schön (1987) who distinguished between two types of reflection; reflection-on-action (looking back at an experience or event with the aim of developing insights that may positively influence future practice) and reflection-in-action ("a way of thinking about a situation while engaged within it, in order to reframe or solve some breakdown in the smooth running of experience", Johns, 2004, pp 1). Johns (2004) refers to layers of reflection and suggests a process of moving from 'doing reflection' to 'reflection as a way of being' (pp.2). For the participants, the narrow construction of the SPM also does not acknowledge therapist factors, whereas their broader version of the model would explicitly. Therapist factors included the assumption that experience would undoubtedly and desirably result in changes in practice through reflection, whereas the narrow conceptualisations of EBP and the SPM, according to participants, view the therapist as almost a fixed unchanging entity.

Rather than 'blindly' applying research or a manual to all clients who may meet a certain diagnosis or presenting problem (which the participants viewed a narrow definition of the SPM as advocating), they suggest a reflective approach would consider whether such recommendations were appropriate for each particular client and design an intervention accordingly. The themes generated within this area indicated participants viewed the key features of the reflective aspect of the model as being a practitioner who is person centred, and inherently flexible, responsive, adaptable, and creative.

The emphasis on including a critical element within the model related to the need to appraise the research underpinning recommendations such as those within guidelines which form the evidence base. The perception by participants that narrow definitions of evidence promote a particular view of the world presented as 'truth', was highlighted as a reason for a more critical approach to be warranted. The critical element of the CRSP was considered by participants to incorporate the skills of problem solving, creative thinking, and a dynamic and flexible approach to their practice. The CRSP could be said to acknowledge that: "Individuals do not fit textbook categories and the real evidence-based challenge for therapists is what works for whom in local practice contexts"(Larner, 2003, p30-31).

In exploring the development of the clinical psychology profession Newnes (1996), provides a comprehensive overview which concludes with a call for the profession to adopt a more self-reflexive and critical stance (Newnes, Haagan & Cox, 2002). The development of a CRSP model could be considered to capture such a stance, which some view as a relatively recent development within clinical psychology's construction of itself (Nel, 2010). Some of the tensions which exist in the current health care climate (as perceived by these trainees) relate to whether there is the place to reflect, and/or the space to use this model to guide practice, or whether there is a push or move towards enforcing a more restrictive version of the EBP and SP models, which is more dictatorial in its recommendations. The impact of this for participants was uncertainty as to whether certain practice decisions would be considered either unethical or unjustifiable.

### *Therapist evidence and expertise*

Participants' perception of the EBP model was that it did not view therapist expertise as being a valid form of evidence. Within the wider literature Gryphonck (2006) considers the dichotomy created by EBP is one wherein the overarching aim is the replacement of opinion-based actions with evidence-based actions, and that all reasonable practitioners should be concerned with achieving this (Hampton, 2002). Participant's perception that the opinion of the psychologist should be secondary to research-evidence was considered to undermine the skills felt to underpin and define the CRSP; intuition, flexibility and adaptability. The difficulty with such an assertion (that all actions should be evidence-based) according to Gryphonck (2006) "is that EBP is an ideology but one that violates its own ideology. Claiming that opinion should give way to evidence, while not being able to provide evidence for such a statement, is itself neither logical nor rational (Couto, 1998)" (p.135).

As Bamford (2009) asserts, "as clinical psychologists we are trained to work in a dynamic, flexible and integrative way- indeed, the integrative nature of psychological interventions has been said to be an advantage over other professions". If the ability to utilise these skills is undermined then this compromises the position of the psychologist. The potential impact of this for the profession was considered within talk around the IAPT programme and concerned professional identity and boundaries, and competing discourses.

### *Competing discourses: Economic and Political factors*

Participants expressed the view that the 'restrictive' versions of the EBP and SPM, promoted research from a positivist paradigm; an objective truth was not consistent with their perspective, rather they

considered there could be many ways of seeing the world. This essentially seemed to encapsulate a more postmodern perspective which was reflected in their construction of the 'friendly' EBP and SP models. One of the difficulties for psychologists, as was identified within the focus groups, is that historically psychological research has aligned itself with the philosophy and methods of natural science; "The principles of natural science define the 'scientific paradigm'... in the human sciences...(this) strives for an objective evidence base, common to all (not subjective, esoteric, unreplicable, based in intuition or some other form of incommunicable claim to knowledge)....(and) is focused on generality" (Bolton, 2002, pp.4-5). Within the theme which captured the consideration of the economical factors which may influence the type of research conducted; participants may be acknowledging a similar perspective to that outlined below. It is argued that the perspective of proponents of EBP is based on "...the realisability of an ideal of science as the impartial, disinterested seeking after truth resulting in objective knowledge, (whereas) science is an inherently social activity with its own ends and means, and those ends and means are circumscribed by the interests and concerns of those who control the signification and dissemination of information and knowledge." (Sturdee, 2001, pp. 61). That research has political implications was raised in the focus groups; the term methodolatry has been used to refer to; "A range of views, within the qualitative research community, about the relationship between methodological and ideological considerations. At one end of the continuum, there are those who argue that qualitative (and indeed all) research serves a political purpose in that it either challenges or supports the (political, economic, social, cultural) status quo, and that, therefore, ethical and political issues need to be at the top of the research agenda (e.g. Parker, 1992)." Certainly this was the view of the members of the focus groups, this led to viewing one of the future roles of the clinical psychologist as



being the promotion of alternative perspectives and a widening of current conceptualisations of evidence.

The increasing emphasis on CBT was a cause of concern for participants as this was felt to potentially limit the skills of the clinical psychologist, in that having a model determined *a priori* undermined a formulation driven approach, considered to be a key skill of the clinical psychologist. Harper (2008) considers; “CBT’s more realist epistemology fits well with the evidence-based practice movement and, of course, the commissioners of research have a major influence on the take-up of qualitative research in clinical psychology” (pp.431). Participants talk concerned the perception that EBP can promote a simplistic view of practice; while CBT may be recommended, participants reflected on how representative that may be of actual clinical practice, where therapists trained in a variety of approaches may utilise any number of skills and strategies depending on the needs of the client and may not deliver single approach treatments (Bower, 2003).

### *Containment and professional identity*

Participants had mixed responses to having clearly delineated guidance for practice; on the one hand more prescriptive practices were considered to constrain practice, on the other, they provided containment and reassurance for the trainee. Grypdonck (2006) states that EBP can provide certainty over uncertainty and that “is very attractive to managers, as it renders many issues objective and makes care more predictable and controllable” (p.1375). However, an alternative perspective is that: “Too many popular accounts of science take it as read that ‘uncertainty’ is a bad thing and ‘evidence’ is a good thing...given this perception, the honest disagreement and debate which are the essence of a healthy scientific community

become a cause for suspicion...with the recognition that a degree of uncertainty is an essential feature of the human condition, come virtues of humility and tolerance: one is able to be open to alternative approaches and realise one's own assumptions and judgements are just one set among many. In the absence of any one certain method of discovering the truth, it is rational to tolerate a plurality of approaches: to refuse to do so is to close off potentially fruitful avenues of investigation *arbitrarily* (Feyerabend, 1988)".(Loughin, 2002, pp. 11).

In terms of professional identity the SPM was considered by participants to provide an overarching framework for the clinical psychologist which participants felt provided them with a sense of professional identity and a means by which they could define their role and highlight their skills. This was considered important in light of the recent IAPT programme which has seen a vast increase in the number of psychological therapists being trained; participants felt it was increasingly necessary to advertise the uniqueness of, and strength of, the role, in response to the potential threat from these new therapists. Recently the Division of Clinical Psychology and the British Psychological Society have published a guideline outlining the core purpose and philosophy of the profession, within which they too implicitly recognise the need to emphasise the range of skills of the clinical psychologist within the changing healthcare climate and in doing so take an optimistic approach, they state; "Clinical psychologists are more than psychological therapists; they are scientist practitioners.... The ability to design and undertake professional practice with individuals, groups, organisations and systems... is becoming more and more valuable in the drive towards evidence based practice. In addition, research competence and the critical evaluation of research activity is a skill which will be

increasingly in demand by health and social care commissioners and provider organisations in the coming years. (BPS, 2010, p2-3).

## ***4.2 Critical Appraisal***

In focusing on the topics of EBP the SPM, IAPT and CBT which are very current and relevant within the field of clinical psychology, I wanted to contribute to the existing research and debates on these topics within my profession. I believe I have achieved this and I outline the contributions of this research within the strengths section below. Prior to this it is useful to reflect on some of the limitations of the study. The concluding chapters consider the clinical implications and future research.

### ***4.2.1 Research Limitations***

Notwithstanding the notable strengths of the research, several methodological limitations are noteworthy, these include:

The Information sheet contained quite a lot of information about the topic area; this may be considered as providing participants with too much information; however, this was a considered decision with my research supervisor as it was felt this would stimulate conversation. However, it did not appear to be the case that any of the participants had read around the area, with many of them having forgotten what the topic was by the time it came to the focus group day.

#### ***Method of data generation***

While the choice of focus group methodology was appropriate to address the research aims, a number of difficulties were encountered. As previously highlighted, recruitment was an issue; the researcher aimed to recruit 6 participants to each focus group; this was achieved for two of the focus groups. However, on the day of one

the focus groups one participant had to withdraw due to ill health. In respect of the third focus group, only three had confirmed in the lead up to the prearranged date. It was decided to continue with the group as planned (due to time constraints) and the researcher arrived early before the teaching day ended with the hope of recruiting more on the day. Unfortunately I was unable to recruit further; I expected difficulties as participants were also in the midst of completing their own research projects and time was precious. Had I chosen a different design such as semi-structured interviews I may have required fewer participants, may have increased recruitment, partly as there may have been more flexibility in choosing a time convenient for the participant (there may also have been an option to conduct the interview via telephone thereby increasing flexibility further). However, as illustrated previously, this method was not considered the most appropriate to address the research aims. In part as participants may not have considered these topics in any depth and the concern was the researcher may have provided more prompts or questions which may have compromised the data produced.

The use of questionnaire methodology was an alternative consideration, (having the potential to recruit participants from clinical psychology courses across the country may have been advantageous) and while flexibility for the participants in terms of completing it at a convenient time is a strength; the response rate with such a methodology is notably low (Yardley, 2000). The same concerns remain with this method of data collection in that participants may not have considered the topics in any depth and this may affect the data produced. The limitations of this method in this field of study have been outlined previously and the design of the current study was in response to identified limitations of the use of questionnaire and semi structured interviews utilised in previous research in this area (Lucock, Hall and Noble, 2006).

Further factors related to the focus group include that the group was a self selected sample, this may have meant that those with an interest in this area volunteered, which potentially may have meant that only those with particularly strong opinions participated. However, feedback from the participants indicated this was not the case.

All participants were female; however this was representative of the gender break down from the participating courses.

Conducting the focus groups in the same room participants had been in all day could be considered a weakness as Vicsek (2007) considers it important to consider the environment within which the focus group was conducted if these factors may have had an impact on the discussion. Two of the groups took place in the same room in which they had teaching during that day. This was a consideration when planning the groups, there were pros and cons, and practical considerations which influenced this aspect. Familiarity with their surroundings may have helped the participants feel relaxed, whereas moving to a different room may have 'refreshed' them after a long day of teaching, however, this was not possible due to the limited availability of rooms and therefore a break was given in between ending teaching and starting the group.

That participants knew each other may have influenced how they responded; it has been suggested that groups of acquaintances may be motivated to achieve consensus and may show a greater degree of conformity (Macnaghten & Myers; Vicsek, 2007). Related to this is the influence of familiarity and the fact that group members may remain in frequent contact following the group, which may render them less likely to express views which may be more extreme compared to the group 'norm'; this stems from research indicating

strangers are more willing to declare and maintain their opinions within a focus group (Litosseliti, 2003). However, my experience was that participants expressed a variety of opinions, with the discussions including multiple perspectives.

Were I to utilise the focus group as a method of data collection in the future, I would ensure I enlisted the support of a research assistant to remain outside the discussion and observe and record notable interactions within the group. While I made some notes in this regard following the groups, my attention during the discussions was primarily focused on the content and facilitating the group.

It also may have been useful towards the end of the group discussions to enquire if any of the participants had experienced any direct teaching on any of the topics covered, and if so a brief outline of this. However, as at least one member in each focus group made a comment to the effect that they hadn't considered this area(s) in any depth previously, led me to believe they had not.

### *Method of analysis*

The choice of thematic analysis was driven by the research aims; the intention was to focus was on what was said, with a view to establishing themes across the data set. The creation of themes is a central feature in many forms of qualitative analysis; Thematic Analysis has only relatively recently been acknowledged as a method in its own right. Broadly speaking there are two main sources which elaborate this method; the author considered the approach outlined by Boyatzis (1998) to be implicitly positivistic in that he emphasises interrater reliability and validity. The author does not consider this to be a necessary feature in order to measure the credibility of an analysis, and from her epistemological position would expect two

different 'raters' would produce two unique analyses which may likely focus on differing features of the data, according to their own reading and interaction with the data. Consequently the description of Thematic Analysis outlined by Braun and Clarke (2006) appealed, partly due to the clarity with which they outline the method; and due to the flexibility it offers in that it can be approached from a number of epistemological positions.

During the analysis, while the method enabled the generation of themes to capture interesting and relevant aspects of the data, there were features of the data that I felt I could not capture or explore using TA. I began to consider how other methods of analysis, such as discourse analysis, could have explored these further. For example it may have been interesting to explore the trainees' positions and positioning of themselves. The use of the term 'they' was used to refer to 'an other' sometimes identified later in the narrative as referring to 'the course' but often remained unidentified. The participants appeared to construct this other(s) as a strong influencing factor(s), I began to view what was being conveyed as representing a more subjugated narrative, I understood this as potentially reflecting the participants position as trainees whom may have considered themselves as being in a less powerful position (in relation to their course, or supervisor); I would have liked to explore this further. I also reflected on whether Social Identity Theory (Tajfel & Turner, 1979) may account for the participants (and arguably the professions') drive to emphasise its difference from other psychological practitioners, with current changes such as IAPT representing a threat to the profession as identified within the current study. This perspective may be evident elsewhere as highlighted in the following quote by Pilgrim and Treacher (1992) who refer to the SPM, and assert it is, "a crucial part of the profession's rhetoric in establishing superiority *vis-à-vis* other professions such as psychiatry,

social work and nursing.” (p. 82). Milne (2007) also includes political factors such as EBP and governmental drives to reduce differences between professions (in the form of Agenda for Change) as factors contributing to within- and between- professional frictions. This was highlighted in the analysis within the theme identifying potential threats to the profession as described by the participants.

Discourse analysis may have allowed me to explore the language used by focusing not just on *what* was being said but *how* it was being said and in turn how this may relate to the wider societal context. Conducting this research has confirmed and continued my interest in how language creates and defines, and as a result how psychological theories and therapy models do so. I have become increasingly aware in my clinical practice of the language used by myself and those I work with and how this can create and constrain certain narratives.

#### *4.2.2 Strengths of the research*

The following section outlines the perceived strengths of the research; the new knowledge generated by this research is also elaborated.

The current study does not attempt to make claims that are generalisable, primarily as I am not aiming to present my findings as ‘truth’, a notion I find questionable within my view of the world as socially constructed. However, I believe my research can show transferability.

#### *Methodology*

While I have highlighted the limitations of the chosen methodology above, there were obvious advantages. The use of qualitative methodology addressed the limitations of similar research in this area (which has utilised questionnaire and interview methods);



the focus group enabled the concepts to be discussed openly and widely without, for example, the restriction of the questionnaire. The interactive nature of the focus group resulted in dynamic constructions and meaning making; such interaction would have been missed in individual interviews. As highlighted earlier, my experience during informal discussions with clinical psychology colleagues indicated they had not considered in any detail the topics of interest explored within my research. The focus group was therefore ideal; Morgan (1997) highlights the focus group as a particularly useful method of data collection for such topics which may have received little attention. Had I used semi-structured interviews or open ended questionnaires to explore individual constructions of these areas, the data generated may have been relatively limited. This supposition was born out by comments supporting such a position, with participants indicating surprise that they found the topics covered both interesting and that they potentially had far reaching implications within their profession. It was as a direct result of the dynamic discussions that such comments arose.

#### **4.3 New Knowledge generated by the research**

The current study offers an important and significant contribution to the field of clinical psychology in a number of ways.

##### *Evidence-based-practice*

Firstly, the findings indicate that participants initially equated the 'evidence' in EBP to be referring solely to RCT's; this is consistent with previous research conducted in the United States (Luebbe et al, 2007). Due to the difference in training and political contexts between America and the United Kingdom, the transferability of their findings to a UK context could not be assumed. The findings from the current study suggest that for these participants a similar assumption

is made; this supports the transferability of the findings from both studies.

Secondly, not only did participants consider the EBP model to conceptualise evidence as deriving exclusively from a particular type of research method (the RCT); but in doing so they perceived EBP as an approach to practice which ignores or minimises therapist factors and client preference. Interestingly this construction of the model is inconsistent with the definition provided by APA (2006) which explicitly identifies all three elements (research, client and therapist factors) as being an essential part of the model.

This finding extends previous research (Luebbe et al, 2007; Spring, 2007) which has indicated practitioner's can be confused about what EBP means (Wilson et al, 2009). Significantly it also suggests that for these participants they are already practicing in a manner consistent with the EBP model. It may also suggest that criticism directed at the model (both within this research and the wider literature) is based on an inaccurate perception of what the EBP model entails. This has major implications for those who wish to promote and encourage practice consistent with this model.

The findings in the present study may provide an alternative interpretation to that given by Luebbe et al (2007); whose research indicated trainees may rate their supervisor and client-based factors as influencing their intervention choice more than RCTs and systematic reviews. Luebbe et al (2007) were concerned by this finding, believing that if the trainee followed their supervisors advice it was limiting their ability to make their own choices and that this may be problematic for them once they qualify. The findings from the current study may suggest firstly, that participants' may view the RCT method as having limited validity in the context within which they practice, and for the clients with whom they work. Secondly, the findings in the current study may suggest the supervisors influence

over trainees practice, is due to the perception of the supervisor as having greater clinical experience and knowledge from which to base their recommendations to the trainee; and also that the supervisee will be aware they need to pass their placement, so there are potential implications for their success on the doctoral course otherwise. This was not considered in Luebbe et al's (2007) interpretation of their findings.

### *The Scientist-Practitioner Model*

The significant findings from the current study in relation to the SPM include; that contrary to previous research suggesting the SPM is inadequate due to clinical psychologists not viewing the conducting of research as important (Allen, 1985); and that they consider the research literature to be irrelevant to their practice (Barlow, Hayes & Nelson, 1984); the participants in this study perceived research (both conducting, utilising and disseminating) as being a key skill within the SPM, and one which distinguished them from other psychological practitioners. The further value of the SPM for participants was that it was a source of containment and an inherent aspect of how they defined their role and professional identity as clinical psychologists; this finding is consistent with previous research (Corrie & Callanan, 2001; Morton, Patel & Parker, 2008).

Rather than being an outdated model which is no longer relevant to current clinical psychology practice (Head & Harmon, 1990); the findings from this study may suggest that the SPM continues to have applicability, but that the model has changed from its original incarnation. The utility and acceptability of the model, for participants in this research, related to a construction of the model which incorporates and emphasises utilising the model within a critical and reflective framework. Whereas Chinn (2007) suggests reflective practice can be considered in opposition to the scientist practitioner;

the participants within the current study extended the SPM to incorporate reflective practice. As is to be expected within a social constructionist perspective, meaning and concepts are socially and historically constructed. It may be that the current climate of EBP and the perceived limitations of the 'original' SPM, have contributed to the participants adapting the SPM to take into account the changing context, ideas about ways of viewing the world, and a move beyond the dominant positivist paradigm, to incorporate other epistemological positions, and correspondingly drawing on research utilising broader methodology than just the RCT. Interestingly the broader conceptualisation of the SPM, the critical-reflective-scientist-practitioner, may actually be more consistent with the definition of the EBP model than participants were aware. The clinical implications of this are considered below.

### *Psychological therapy provision*

Despite there being much written about the IAPT programme in the psychology field, this study is the first of its kind, as far as the researcher is aware, which has explored perceptions of the programme with clinical psychologist trainees.

Participants expressed concern about the IAPT programme; perceiving the development of a service which is organised around psychiatric diagnosis and specific 'treatments' for certain diagnoses as appearing to represent the narrow version of a SP, and be based upon conclusions drawn from a particular type of research evidence. While such concerns have been expressed elsewhere, it may shed light on participants' perception of EBP and the SPM as not being formulation driven. It may also illuminate their uncertainty about whether their practice (within which they described drawing on a number of therapeutic models and techniques; and utilising evidence from a number of sources) would be questioned; as they perceive the

IAPT programme as recommending standardised interventions using only CBT.

Talk around IAPT led participants to discuss the need to research and promote evidence drawn from both a formulation driven approach and from methods beyond the RCT. The perceived difficulty and circularity in the argument, (about the need to broaden the evidence-base, and the importance of this as a part of the SPM) was considered to be whether the service structures within which clinical psychologists practice, view research as important and ensure time available to conduct it. This may be one of the fundamental obstacles hindering such a change.

One of the criticisms within and towards clinical psychology, arising from the IAPT programme, is the perceived adoption of the medical model within the clinical psychology profession (Nel, 2009). The findings from the current study would suggest that, at least for these participants, a psychological framework of understanding remains primary and they too express concern about psychological services being organised around a medical model with a focus on psychiatric diagnosis.

Smail (1982) argues that as a profession we should question the epistemological assumptions upon which our work is based, not just in the research arena but our clinical practice as a whole. It could be argued that this research is achieving these functions, in exploring some of the models the profession is influenced by (EBP and the SPM) this has incorporated a consideration of the underlying assumptions of much research and its implications for practice.

#### **4.4 Clinical Implications**

In this section the clinical implications for clinical psychology training courses are considered, for clinical psychologists as a whole, and for researchers. This is followed by suggestions for future research.

##### *Implications for clinical psychology training courses*

The importance of exploring how the next generation of practitioners perceive the EBP model has been highlighted (Luebbe et al, 2007). Such knowledge is important partly to ascertain whether training needs to adapt in response to changes in the health services, such as the increasing focus on EBP.

The current study would indicate that training courses may wish to include teaching around EBP, primarily as the participants held an inaccurate perception of the model. Participants held a negative view of the model and conceived it as ignoring or minimising therapist and client factors. Providing teaching and encouraging discussion about the model would enable trainees to have a more informed perspective, and awareness of the multiple debates (including those around the NICE guidelines) which arise from it.

Further teaching and discussion on the epistemological foundations of our underlying theories and models (philosophy of science) may be a recommendation from this research (Hoffman & Thelen, 2010). Anecdotal evidence from my own discussions with other trainees was that this was an area they did not feel confident in, nor really understood (indeed a comment from one of the participants was; "I don't know what that word (epistemology) means"). Smail (1982) states:

Clinical psychologists as a group have...become weary of philosophical debate concerning the 'models of man' which we

espouse...we seem happy to let epistemological and moral issues lie unquestioned while we get on with the practical issues of 'delivering' clinical services. This...seems to me to constitute a dangerous state of affairs, both for ourselves as a profession and for those to whom we offer our services...The danger is that, while we can't avoid having a philosophical stance on intellectual and moral issues, it has become merely implicit, but nevertheless continues surreptitiously to guide and shape our activities in ways we may at some future time come to regret (p. 345; in Pilgrim & Treacher, 1992, p.95).

While it could be argued that; "Courses are aiming to produce clinical psychologists prepared to work in the NHS rather than social constructionists, critical psychologists or family therapists and course staff are not necessarily being employed to be critical psychologists or social constructionists" (Harper, 2004, 159); awareness of some of the debates underlying the notions of 'expert knowledge' is consistent with a more reflective practitioner approach. Prilleltensky and Nelson (2002) suggest, as part of a critical psychology perspective, that teaching explore some of the underlying assumptions within psychology and: "Analyze (the) historical and socially-constructed nature of psychological concepts and discuss the role of social power in according legitimacy to certain theories and not to others." (p.41). It may be interesting in future research to explore the current focus of the EBP movement and CBT within this framework; indeed a related analysis has recently been conducted by Hickman (2010).

Since completing the analysis in the present study and the majority of the write-up; a special issue of the Clinical Psychology Forum (2010, 213) was published, dedicated to the former Bristol clinical psychology doctoral course. Within this Johnstone and Staite (2010) describe the ethos underpinning their course, "While emphasising the importance of evidence-based practice, we also

recognise some of the limitations of a pure scientist-practitioner model... in acknowledging this we (also) encourage trainees to develop...two (further) strands, critical and reflective (thinking)" (p.9). This appears to represent a similar perspective and approach to the participants CRSP in the present study; this adds to weight to the transferability of the findings beyond the current research sample. If one agrees with those within this research and the wider field that a more reflective and critical approach within psychology is warranted, then incorporating these aspects within clinical training may be one outcome, this perspective is held by Trierweiler and Stricker (1998).

Participants expressed concern about what evidence was considered 'acceptable'; further exploring the definition of EBP, which refers to "integrating the best available research" (APA, 2006) may be beneficial. If there is flexibility in how 'best' is interpreted (depending on ones epistemological and theoretical framework), then this may ease some of the concern participants expressed. Clinical training courses may wish to explore these debates with the next generation of clinical psychologists, who will a) be facing such dilemmas, and b) may be able to consider ways to address this in clinical practice.

How trainees conceptualise the SPM may be an area that training courses wish to explore with their students, this may not necessarily be with the aim of defining the 'correct' version of the SPM according to that course ethos (which would be a problematic stance in itself if one takes a social constructionist perspective), but it would open up the area and awareness of the various (and continually changing) interpretations (and debates) around the model. This may be facilitative in trainees developing a more



informed perspective on a model which is arguably central to their profession.

Participants within the current study indicated within their clinical practice they drew on a number of models utilising a number of techniques within a single intervention. That they weren't following a single model added to their sense of uncertainty about how such interventions would be received. With the development of IAPT, clinical psychologists in these services will increasingly see more 'complex' clients (within a stepped care approach, the clinical psychologist generally works at tier 3 and 4). Utilising knowledge from a variety of sources and implementing interventions which draw on a number of therapy models (i.e. integrative practice) may be required to meet their needs, particularly if the current evidence base is not representative of such clients (Dallos, Wright, Stedman & Johnstone, 2006). Training courses may wish to increase their teaching on integrative approaches and working with more 'complex' clients (Kiff, 2009). Such recommendations may be suggested by the current research findings, and on a more informal basis similar sentiments have been expressed by clinical psychologists employed within the authors' current position in a Tier 4 primary care service. Further research may be useful to explore whether such perceptions are representative across the profession, within similar services and beyond.

Participants considered the types of research upon which guidelines and policy documents are drawn should be broadened; they envisaged this may be part of their role post qualifying. The following recommendation may result from these findings: "Our health services are provided in a current context of economic restraint ruled by certain sorts of evidence being acceptable, translated through NICE guidelines. This is unlikely to change, so

perhaps we need to add two further competencies to the portfolio of clinical psychology, namely basic health economics and how to influence NHS policy” (Burns, 2011, p.20).

### *Implications for practitioners*

One recommendation leading from the research may be to increase the amount of practice-based research, this form of EBP may be more acceptable due to its ecological validity (research conducted within the local context taking account of client factors), which may influence practice at a local level. As highlighted within the focus groups, one of the fundamental challenges for those who wish to, a) conduct research, and b) utilise methods currently not prioritised within the dominant version of the EBP model; will be negotiating time to do this, and advocating the importance and significance of knowledge created from a broader range of research methods. Documents such as the New Ways of Working (Turpin, 2007) may provide valuable support in achieving this.

Practitioners may also wish to consider their own understanding of both the EBP and SP models and how they may influence their practice. This may include examining their own constructions around evidence.

As there are various constructions of the models a further recommendation may be to explore with their fellow colleagues, both psychology and if applicable the multidisciplinary team, how they understand these models; this could serve to open up discussion about the role of research and evidence on practice within the local context.

For those practitioners who may offer clinical placements to trainee clinical psychologists, they may wish to consider their own perspective on 'evidence' and whether and how they discuss this with their trainees, in light of the influence the supervisor may have on the trainees practice as indicated by the participants.

### *Implications for participants*

One of the criteria for evaluating a study's worth recommended by Parker (2004) is the relevance or benefit to the participants taking part. Feedback from group members included that they hadn't realised how many aspects of their practice were subsumed by the topics covered. They reported finding it interesting and stimulating and for some participants the outcome of taking part was a desire to consider how they could contribute to influencing the evidence base post qualifying, participating in this research may have stimulated such a drive.

## **4.5 Future Research**

There are a number of interesting future research areas arising from the present study, these include:

Participants identified the importance of highlighting the unique skills of the clinical psychologist; one potential research area may be exploring how other practitioners view the practice of the clinical psychologist. As the focus group illustrated, there was a consideration of the role and also how we convey this to others. Casement (2009) discusses the "blurring of the boundaries between CBT and clinical psychology as a science and a profession" (Casement, 2009, pp.401), this can be seen in recent job adverts whose title ask for a CBT therapist/ Clinical psychologist, there seems to be an equivalence

assumption and if so what does this mean, and how do we address this as a profession? This is particularly salient when considering the many other skills and activities of clinical psychologists beyond the delivery of therapy, as highlighted by participants; and by the Division of Clinical Psychology itself (Mental Health Strategies, 2007).

It may be interesting to explore whether the impact of guidelines is affecting the practice of those clinical psychologists working in primary care services who have incorporated IAPT, in a restrictive way as assumed by the focus group participants.

The use of the term 'evidence-based' was highlighted by participants as suggesting credibility, it may be interesting to analyse various texts utilising discourse analysis as a means to examine and deconstruct the term and further explore how it has come to be such a dominant discourse (Coles, 2010).

As highlighted within the current study, one of the difficulties with research on EBP is the conceptual confusion around the term. This is evident in the very research attempting to explore it (particularly in the United States). The terms empirically supported treatment (EST) and EBP are used interchangeably when they are actually referring to two different things; it is important for future researchers in this area to be clear about the terms they use.

Participants expressed concern that basing their decision making on certain types of 'evidence' may be perceived negatively by others. It may be interesting to explore with qualified clinical psychologists, whether they have experienced any instances where their choice of intervention has been questioned (this may or may not relate to using a therapeutic approach which was not recommended

within a NICE guideline for example), and if so how they negotiated this.

Participants described their practice as frequently drawing on a number of models and techniques within a single intervention; if this is representative of 'everyday' practice; research exploring the outcomes of such integrative practice is surely warranted.

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## **Appendix 1: Manuscript Guidelines**

### **Qualitative Research in Psychology: Manuscript guidelines**

#### Instructions for Authors

Qualitative Research in Psychology aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, and forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

***Qualitative Research in Psychology*** is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research. The journal aims to firmly establish qualitative inquiry as an integral part of the discipline of psychology; to stimulate discussion of the relative merits of different qualitative methods in psychology; to provide a showcase for exemplary and innovative qualitative research projects in psychology; to establish appropriately high standards for the conduct and reporting of qualitative research; to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record; and to place qualitative psychological inquiry appropriately within the scientific, paradigmatic and philosophical issues that it raises.

#### **Types of Manuscripts.**

***Qualitative Research in Psychology*** will publish the following types of paper:



- 1) Theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology
- 2) Empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways
- 3) Debates
- 4) Book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Reviews Editor, although unsolicited reviews will be considered and the journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for ***Qualitative Research in Psychology***, and not to have been submitted for publication elsewhere. Priority and time of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

### **Submission of Manuscript**

Manuscripts should be submitted via the web at <http://mc.manuscriptcentral.com/uqrp>. All components of your paper (including tables and figures) should be contained within a single

document (preferably in Word but files can be accepted from any of the common Macintosh, Windows, or MS-DOS word processing programs). Please send two versions of your paper, blinding one version for peer review purposes (i.e., author names and affiliations removed). The editorial office accepts papers in either UK or U.S. page size formats.

Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order. The following items must be provided in the order given:

**1) Title Page.** Authors and affiliations: Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment his/her present address should be given as a footnote). For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs and offprints will be sent) named with their telephone/fax/e-mail contact information listed.

**Abstract:** Please provide an abstract of approximately 150 words. This should be readable without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content.

**Keywords:** Please provide at least 5-10 key words.

**About the author:** Please provide a brief biography to appear at the end of your paper.

**2) Text.** Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:

1 Heading

1.1 Subheading

1.1.1 Subsubheading

Footnotes should be avoided. If necessary they should be supplied as end notes before the references.

**3) References.** The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style:

**For a book:** Hollway, W. and Jefferson, T. 2000: *Doing qualitative research differently: free association, narrative and the interview method*. London: Sage.

**For an edited book:** Brown, L.M. 2001: Adolescent girls, class, and the cultures of femininity. In Packer, M.J. and Tappan, M.B., editors, *Cultural and critical perspectives on human development*. Albany, NY: SUNY Press.

**For a journal article:** Madill, A., Jordan, A. and Shirley, C. 2000: Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology* 91, 1–20.

**4) Acknowledgements.** Authors should acknowledge any financial or practical assistance.

**5) Tables.** These should be provided on a separate page at the end of the paper and be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

**6) Figure captions.** These should be provided together on a page following the tables.

**7) Figures.** Figures should ideally be sized to reproduce at the same size. All figures should be numbered consecutively in the

order in which they are referred to in the text. Qualifications (A), (B), etc. can only be used when the separate illustrations can be grouped together with one caption. Please provide figures at the end of your paper on a separate page for each figure. Once accepted you will be required to provide a best quality electronic file for each figure, preferably in either TIFF or EPS format.

## **Illustrations**

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

300 dpi or higher

sized to fit on journal page

EPS, TIFF, or PSD format only

submitted as separate files, not embedded in text files

Color illustrations will be considered for publication; however, the author will be required to bear the full cost involved in their printing and publication. The charge for the first page with color is \$900.00. The next three pages with color are \$450.00 each. A custom quote will be provided for color art totaling more than 4 journal pages. Good-quality color prints or files should be provided in their final size. The publisher has the right to refuse publication of color prints deemed unacceptable.

## **Permissions**

Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an

agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher.

### **Proofs**

Page proofs are sent to the designated author using Taylor & Francis' Central Article Tracking System (CATS). All proofs must be corrected and returned to the publisher within 48 hours of receipt. If the manuscript is not returned within the allotted time, the editor will proofread the article and it will be printed per his instruction. Only correction of typographical errors is permitted at the proof stage.

### **Reference**

Downloaded from:

<http://www.tandf.co.uk/journals/journal.asp?issn=1478-0887&linktype=44>

**N.B.** The journal does not have a word limit for manuscript submissions.

## **Appendix 2: University of Lincoln Ethical Approval**

Dear Lynn, many thanks for your revised ethics application. This is to confirm that you have ethics approval from our University from today. Good luck with your research, all my best,

Emile

Emile van der Zee PhD  
Principal Lecturer in Psychology  
University of Lincoln  
Lincoln LN6 7TS  
evanderzee@lincoln.ac.uk  
<http://www.lincoln.ac.uk/psychology/staff/683.asp>

NB: This is a copy of the ethical approval email, received 9/10/09.

## Appendix 3: Participant Information Sheet



Trent Doctorate  
in  
Clinical Psychology



Faculty of Health, Life  
and Social Sciences

Institute of Work,  
Health & Organisations

### **Information Sheet**

**Title:** Trainee Clinical Psychologists' perspectives of evidence-based practice and what this means in relation to their clinical work.

**Researcher:** Lynn Chapman

You are being invited to participate in this research conducted by Lynn Chapman, because you meet the criteria of being a 3<sup>rd</sup> year trainee clinical psychologist enrolled on a doctoral programme at one of three courses (names of university).

In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This brief gives you detailed information about the research study.

#### **Why is the research being carried out?**

The research is being carried out in part fulfilment of a doctorate in clinical psychology, it will be written up as a thesis. It may also potentially be submitted for publication in a relevant journal.

#### **What is the research about?**

There are a number of debates within the field of clinical psychology and psychotherapy, regarding the concept of evidence based practice and what this means. Recent developments within mental health services such as Improving Access to Psychological Therapies (IAPT) have implications for clinical psychologists and may be said to relate to the debate around evidence-based practice. This research aims to

explore the concept and several related issues, with a number of trainee clinical psychologists within the midlands area.

**What will I have to do if I take part in the study?**

If you volunteer to participate in this study, you can contact the researcher (contact details provided at the bottom of this sheet). The information sheet is included with this email. Please read this and I will answer any questions you may have. If you volunteer to participate in this research I will bring consent forms to the focus group, which you will be asked to sign prior to the commencement of the focus group.

**I propose (Date) for the focus group (this will take place .....).**

The focus group will take place at your university base. It will involve you and up to 5 of your fellow 3<sup>rd</sup> year trainees; during this the group will be asked to discuss the questions or statements provided by the researcher.

The groups will be tape recorded and transcribed for analysis. The group will last approximately 40 minutes.

**How many people will be in this study?**

There will be three focus groups held, one at each university site, each group will contain 6 participants, giving a total of 18 participants.

**What are the possible risks of participation?**

The researcher cannot foresee any risks to the participants. There may be some inconvenience in terms of committing the time to participate, however this is envisaged to be no more than 1.5 hours.

In the unlikely event that you feel distressed or otherwise following the focus group, you may contact my research supervisor to register your comments, or for debrief purposes.

In order to conduct this research it has first been approved by the researcher's University Ethics board.

**What are the possible benefits?**



Possible benefits include contributing to the literature on this area, which is a very salient issue within the clinical psychology and psychotherapy field.

### **Confidentiality**

All personal information including demographic information will be stored in a secure cabinet at the University of Lincoln. Only the researcher and the research supervisors will have access to this if required. The tape recording of the group will only have the university name written on it (e.g. Sheffield) and the date it was recorded. As such the audiotapes will not have any personally identifying information on them. These tapes will be reviewed by the researcher, the transcriber (who will be required to sign a confidentiality agreement) and may be accessed by the university to check the research. The above information will be stored for 7 years by the university (as per university policy) then destroyed. Participants will not be identified in any way during the write up or dissemination of the research.

### **Can I withdraw from the research?**

If you volunteer to participate in this research, once the focus groups have been conducted it will not be possible to withdraw your contribution. This is due to the fact that participants will not be identified on the recording of the focus group. As such it will not be possible to identify individual participants' responses and so removal would not be possible.

### **Will I be paid to take part in this research?**

If you agree to take part, there will be a £30 raffle draw for each focus group; the prize will be in book tokens.

### **Will there be any costs?**

I cannot envisage there will be any costs for you.

### **If you would like to take part in this study, or if you have any questions:**

Please contact Lynn Chapman at the University of Lincoln on: 01522 886029 (this is the Clinical Psychology Faculty and a message can be left, I will return your call as soon as possible).

Alternately you can contact me via email on:  
07091896@students.lincoln.ac.uk

The university research tutor Roshan das Nair can also be contacted on 0115 846 6646.

**Thank you for taking the time to read this.**

## Appendix 4: Participant Consent Form



Trent Doctorate  
in  
Clinical Psychology



Faculty of Health, Life  
and Social Sciences

Institute of Work,  
Health & Organisations

Participant Identification Number:

### CONSENT FORM

Title of Project: Trainee Clinical Psychologists' perception of evidence-based practice and what this means in relation to their clinical work.

Name of Researcher: Lynn Chapman

Please  
initial box

1. I confirm that I have read and understand the information sheet dated July 2009 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐

3. I agree for the interview to be audio taped and the contents transcribed.

☐

4. I agree the above information can be used in the research write-up and that this may be published.

☐

5. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

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---

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Name of researcher

Date

Signature

**Appendix 5: Participant Demographic Form**



Trent Doctorate  
in  
Clinical Psychology



Faculty of Health, Life  
and Social Sciences

Institute of Work,  
Health & Organisations

**Research participants’ demographic data**

**Age.....**

**Gender.....**

**Ethnicity.....**

**Preferred theoretical approach (if you have one, e.g. CBT,  
Psychodynamic, Integrative/ eclectic, ACT  
etc).....**

**For your thesis which methodology have you chosen  
(qualitative/ quantitative) and why did you chose this  
approach?**

.....  
.....  
.....

## Appendix 6: Transcriber Confidentiality Form



Trent Doctorate  
in  
Clinical Psychology



Faculty of Health, Life  
and Social Sciences

Institute of Work,  
Health & Organisations

### **Transcribers: Confidentiality Agreement**

I, \_\_\_\_\_, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Lynn Chapman related to her doctoral study on "Trainee Clinical Psychologists' perception of evidence-based practice and what this means in relation to their clinical work.".

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;
2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Lynn Chapman;
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;
4. To return all audiotapes and study-related documents to Lynn Chapman in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcribers' name (printed) \_\_\_\_\_

Transcribers' signature \_\_\_\_\_

Date \_\_\_\_\_

## Appendix 7: Focus Group Schedule



Trent Doctorate  
in  
Clinical Psychology



Faculty of Health, Life  
and Social Sciences

Institute of Work,  
Health & Organisations

Title: Trainee Clinical Psychologists' perception of evidence-based practice and the implications for clinical practice.

### Focus Group Schedule

Introduction (recap on purpose of project, procedure, ground rules)

1) What does evidence-based practice mean to you?

- Aim to assess general conceptualisation
- Are there any other aspects to this?
- Is there a discussion of what constitutes evidence? If not ask, what do we understand 'evidence' to be?

2) What does the term scientist-practitioner mean to you?

3) How does Improving Access to Psychological Therapies (IAPT) fit into this picture of EBP?

4) Are there any other issues that haven't been raised that you feel are relevant to this topic?

Conclusions (summary, thanks and debriefing)

## Appendix 8: Participant Debrief



Trent Doctorate  
in  
Clinical Psychology



The University of  
Nottingham

Faculty of Health, Life  
and Social Sciences

Institute of Work,  
Health & Organisations

**Title:** Trainee Clinical Psychologists' perception of evidence-based practice and what this means in relation to their clinical work.

### **Research De-Brief**

Thank you for taking part in this research. The research has been carried out to see if some of the common debates within the literature around evidence-based practice are salient for trainee clinical psychologists.

Research to date has used different methodology, or included a number of professionals, this research aimed to focus on a homogenous group, and provide a more open exploratory forum for participants to express their views on this topic.

Previous research has also focused on factors that may facilitate or impede uptake of the types of recommendations for practice that arise from research, varying interpretations of what constitutes evidence-based practice has been identified as an issue within this.

If you would like any further information once the research has been completed, feel free to contact me: Email [07091896@students.lincoln.ac.uk](mailto:07091896@students.lincoln.ac.uk), or telephone: 01522 886029.

If you have any concerns or would like to speak to my research tutor you can contact

Roshan das Nair on 0115 846 6646.



## **Background references**

Lucock, M.P., Hall, P., & Noble, R. (2006). A survey of influences on the practice of psychotherapists and clinical psychologists in training in the UK. *Clinical Psychology and Psychotherapy*. 13. 123-130.

Miles, A., Hampton, J.R., & Hurwitz, B. (Eds). (2000). *NICE, CHI and the NHS Reforms: Enabling excellence or imposing control?* London: Aesculapius Medical Press.

Several issues of the Clinical Psychology Forum (Number 181, January 2008, Number 190, October 2008,) British Psychological Society.

**Thank you very much for participating.**